TATAU POUNAMU
Ki Te Tai o Poutini

MANAWHENUA ADVISORY GROUP

Friday 12 November 2021

@ 10.00 am Tatau Pounamu Board Meeting

Join Zoom Meeting: Meeting ID:

Agenda and Meeting Papers

All Information Contained In These Committee Papers Is Subject To Change

AGENDA OF THE TATAU POUNAMU MANAWHENUA ADVISORY MEETING

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

TATAU POUNAMU MANAWHENUA ADVISORY MEETING

Te Nīkau - Corporate Board Room

Zoom Link: To be Advised

Meeting ID:

Friday 12 November - 10.00am – 12.30pm

KARAKIA

ADMINISTRATION

Apologies

1. Interest Register

Update Interest Register

2. Confirmation of Minutes of Previous Meetings

Previous meeting minutes – 15 October 2021 – *Chair.* 10.00am

3. Carried Forward/Action List Items

4. Discussion Items 10.15am

- Covid 19 Update – *See report attached*
- Working group and committee vacancies

  ALT nomination
  Disability Group nomination
- Transition Planning Work
- Mental Health update
- Consumer Council
- Mana Taurite – Transalpine Work plan FY22
- Alliance Update
- Commissioning Framework
- Pae Ora
- MHP Dashboard

REPORTS

5.	**GM Māori Health Update**	Gary Coghlan - *General Manager*	FYI only
6.	**Chairs Update**	Susan Wallace - *Chair*	FYI only

Presentations

7. Mana Ake - Update from Davina Ruru and Sarah Fawthrop

Māori Vaccination strategy – Helen Gillespie

Tatau Pounamu - Disclosure of Interest

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

TATAU POUNAMU ADVISORY GROUP MEMBERS INTEREST REGISTER

Susan Wallace - Chair Te Runanga o Makaawhio

- Member, Te Runanga O Makaawhio
- Member, Te Runanga O Ngati Waewae
- Director, Kati Mahaki ki Makaawhio Ltd
- Director, Kohatu Makaawhio Ltd
- Co-Chair, Poutini Waiora Board
- Area Representative – Te Waipounamu Maori Women's Welfare League
- Representative, Te Runanga O Ngai Tahu (Makaawhio)
- Trustee, Te Pihopatanga O Aotearoa Trust

Ned Tauwhare - Ngati Waewae Representative

- Member, Te Runanga O Ngati Waewae
- Iwi Engagement Manager (Kawatiri)
- Buller District Council (Iwi Rep)
- All Buller District Council Sub-committees (4)
- Buller District Council Recovery Governance
- Oparara Arches Governance
- Kawatiri Cycle & Trail Trust
- Coaltown Museum Trust

Chris Auchinvole – Board Representative

- Director Auchinvole & Associates Ltd
- Justice of the Peace
- Daughter-in-law employed by Otago DHB

Joseph Mason - Ngati Waewae Representative

- Greymouth High School – Te Reo Teacher

Richelle Schaper – Te Ha o Kawatiri Representative

- Chair for Northern Alliance Work-stream.
- Member of Oranga Tamariki Care and Protection for Kawatiri
- Tu Pono Connector for Te Ha o Kawatiri
- Project Lead for Kawatiri Maara Kai

MINUTES OF THE TATAU POUNAMU MANAWHENUA ADVISORY MEETING

MINUTES OF THE TATAU POUNAMU MANAWHENUA ADVISORY COMMITTEE MEETING
FRIDAY 15 October 2021
Corporate Board Room - 10.00 AM

PRESENT: Susan Wallace, Te Rūnanga o Makaawhio Representative (Chair) (Zoom)
Chris Auchinvole, WCDHB Board Representative (In person)
Ned Tauwhare, Te Rūnanga O Ngāti Waewae Representative (In person)
Gary Coghlan, General Manager Māori Health (Zoom)
Marie Mahuika-Forsyth, Te Runanga O Makaawhio Representative (Zoom)
Anne Ginty, Mawhera Community Representative (Zoom)
Kyle Parkin, Portfolio Manager, Māori Health (In person)
Marion Smith, Portfolio Manager, Māori Health (In person)
Philip Wheble, General Manger, West Coast DHB (In person)

MINUTE TAKER: Melanie Wilson

APOLOGIES: Joseph Mason, Te Rūnanga O Ngāti Waewae Representative
Richelle Schaper, Kawatiri Representative

Mihi Whakatau/Karakia
Gary Coghlan

AGENDA

1. DISCLOSURES OF INTEREST.
1. Updates/amendments discussed.

2. MINUTES OF LAST MEETING.
1. Minutes of the previous meeting (15th October 2021) agreed as a true and correct record.
Moved: Chair **Second**: Ned Tauwhare

3. ACTION POINTS FROM PREVIOUS MEETINGS.
1. Disclosure of Interest.
Members to email any updates of disclosures of interest before the next meeting.
2. Suicide Prevention.
Reschedule presentation by Suicide Prevention Co-ordinator.
3. Working Groups.
Hauora Team to prioritise working groups/committees and email to members prior to next meeting.

4. DISCUSSION ITEMS / A G E N D A.

1. COVID 19.
   a. Discussed West Coast DHB Covid 19 response and vaccination.

   b. Key aspects, objectives and Strategies.
   - Self-isolation, quarantine process planning - Hauora team currently involved.
   - Self-isolation plan, to send out to whanau.
   - Vaccination is still the best defence.

- Marie Mahuika- Forsyth in her role as Covid Champion for Poutini Waiora expressed concerns around covid comms. Marie to contact Veronica Baldwin the Poutini Waiora Covid Lead.
- Information package is currently being developed by the Ministry.
- Option to use Telehealth is being explored - Julie Lucas - Nurse Director Operations, has sent a draft pamphlet to Hauora Maori for review and comment.
- Presentation received from Covid Lead, analysing Māori specific data extrapolated by age, uptake and gender.
- Current Covid focus: Drive through clinics happening at Westport, Greymouth and Hokitika.

2. Working Group and committee vacancies.
   a. List of working groups, committees requiring Māori representation has been evaluated and prioritised. Priorities identified: Disability Steering Group, Central Alliance Work Stream and Alliance Leadership Team (ALT).

   b. Key points.
   - Tatau Pounamu discussed potential candidates for ALT. Crucial to build capacity of Māori who can contribute.
   - Dr Matt Sollis to be approach.

   - Michael Nolan is a member of the Disability Steering Group. Michael to be approached to be a contact for Hauora Maori.

3. Workforce Development - Build Capability and Capacity
   a. Kaiawhina (rebranding of health care assistants, home based support and allied health assistants) currently undergoing a review of these positions and what this means in terms of delivery to the community.

   b. People and Capability – Equity roles – West Coast and Canterbury DHBs based in Christchurch visited and presented their draft workforce development plan Mana Taurite to Hauora Team.

   c. Key aspects, objectives and strategies.
   - Primarily focused on increasing the current workforce diversity and equity, growing and developing the Māori workforce.
   - Guided by the following principles.
     - Whakamanea – Attract
     - Kimi Kaimahi – Recruit
     - Pupuru - Retain

4. MOU – Discussed
   a. Leave the current MOU in place.

5. Transition Planning Work / Assessment Tool.
   a. Self-assessments completed – attached.
      - Report needs to be complied and sent to the Transition unit.

6. Mental Health update – *See GMs report.*

7. Annual Plan.
   a. Discussed – MOH has yet to approve.
      - Summary attached.

8. Consumer Council.
    a. Discussed.
        - Development of values and principles document. Davida Simpson, Miriama Johnson, Rachael Forsyth, Nikki-Leigh Wilson-Beazley, Helen Rasmussan, to be approached to be involved.
        - Rangatira to be identified and invited to attend.
        - Ned Tauwhare happy to stay on the Consumer committee, approach Miriama and Davida Simpson to also attend.

5. GM Māori Health Update.

a. Report taken as read.

6. Chairs Update.

a. Nil received.

7. Assisted Dying legislation – Graham Roper, CMO WCDHB.

a. Graham Roper gave an overview of the End of Life Choice legislation due to come into effect by the 7th of November 2021.

b. Key Points.
    - The Support and Consultation for End of Life in New Zealand (SCENZ) group will be based in Wellington. This will be managed independently from DHBs.
    - DHB and Primary Care to submit their plan to the MOH on how this is to be managed, by 7th November.
    - Assist dying workforce will be separate from the DHB.
    - Timeframe of engagement and activation will depend entirely on the availability of the medical practitioners.
    - Health care workers are not to raise this as an option. The enquiry is to come from the client. Training to support the health workforce on how you respond to this question is currently being investigated.
    - It is important that practice of Tikanga is followed for the patient and whanau

c. Key Steps.
    - Two independent assessments are completed by medical practitioners.
    - A third assessment by a psychiatrist may have to be completed to determine the person is competent to make the discussion.

For more information: https://www.health.govt.nz/our-work/regulation-health-and-disability-system/end-life-choice-act-implementation/end-life-choice-act-statutory-bodies-and-governance

8. Phil Wheble – WCDHB GM Report.

a. Key Points.
    - Covid vaccination program
        - Continuation of strength testing the system of Covid responses and how it is managed in our facilities.
        - Equipment Respirators - staffing is our main concern, 5.2 FTE required per patient.
        - Outline of Canadian Care model – information to be sent to Tatau Pounamu
    - Concrete foundations are currently being poured in the new Hospital facility in Kawatiri.
    - Providing care and caring for our staff continues to be a challenge as we build resilience across the team.
    - The Mental Health facility business case has now been submitted to Wellington.
    - Work is progressing with Poutini Waiora to align the strategies of Pae ora and Rural Generalism.

9. OTHER DISCUSSION ITEMS

1. Meeting Attendance.
   a. Concerns raised about attendance to meetings, full complement is required.

2. EMT.
   a. Meeting has been arranged next week with clinical leads to discuss prioritising Maori into planned care, surgeries and outpatient clinics.

3. Oral health.
   a. Discussed new oral health strategy - the application of fluoride onto Māori children's teeth by a kiaiwhina workforce in the home.

4. Breast screening.
   a. Two dates have now been set for Māori clinics to look at both breast and cervical screening. These clinics will be held in TeNikau, afterhours.

Meeting ended at 12.30pm.
Next meeting is to be held at Board Room on the Friday 12th of November 2021.

TATAU POUNAMU

ACTION LIST ITEMS 15 October 2021

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Item No	Meeting Date	Action Item	Action Responsibility	Reporting Status
1.	October 15	1. DISCLOSURES OF INTEREST. - Action: Members to email any changes re their disclosures of interest, before the next meeting.	**All Members** (To email to PA – MW)	December Meeting
2.	July 09	3.2 Suicide Prevention. - Action: Reschedule Suicide Prevention Coordinator to the next meeting.	Gary Coghlan, Kylie Parkin	December Meeting
3.	July 09	3.5 Working Groups. - Action: Hauora Team to prioritise working groups/committees and email to members prior to next meeting.	Hauora Team	December Meeting
4.	October 15	4.1 Covid 19. - Action: Creation of an easy Self isolation plan document. Marion Smith to put together -look at civil defence model, for whanau who need to isolate, due to covid in the house hold. - Action: Self isolation, quarantine process - Chairs report to the Board to include, that there is an obligation under the MOU to be early when it comes to major strategies that will effect Māori communities. - Action: Self-isolation review meeting organised. - Action: Marie Mahuika-Forsyth to talk to Veronica Baldwin. - Action: Email Patricia Joseph in the Ministry of Health to find out about the information package being developed. - Action: Philip Wheble – Send through Webinar link for Canadian Covid care model to Tatau Pounamu.	Marion Smith Susan Wallace Kylie Parkin Marie Forsyth Kylie Parkin Phil Wheble	December Meeting
5.	October 15	4.2 Working Groups. - Action: Organise a meeting with Michael Nolan who is currently serving on the Disability committee. - Action: Email the Disability Steering Group application out with assurance that support will be given by Tatau Pounamu. - Action: Reframe advertisements for positions to be placed in the newspaper. - Organise a meeting with Dr Mathew Sollice to discuss ALT nomination.	Marion Smith Melanie Wilson Marion Smith / Melanie Wilson Kylie Parkin	December Meeting

Item No	Meeting Date	Action Item	Action Responsibility	Reporting Status
6.	October 15	4.3 Workforce Development - Build Capability and Capacity. - Action: Hauora team to send through information about the workforce numbers and rolls of Kaiawhina in the DHB to Susan Wallace. - Action: Invite the Equity team to the next Tatau Pounamu meeting. - Action: Send through the Equity team Workforce Plan to Chair.	Kylie Parkin Marion Smith / Melanie Wilson Marion Smith	December Meeting
7.	October 15	4.4 MOU. - Action: Chair to have discussion with other areas to see what they are currently doing around their MOUs. - Action: Chair to discuss MOU with Rick Barker.	Susan Wallace Susan Wallace	December Meeting
8.	October 15	4.5 Transition Planning Work / Assessment Tool. - Action: Clarification required on the transition plan, training and completion. - Action: Meeting to be organised to discuss and complete the transition plan assessment.	Marion Smith Kylie Parkin	December Meeting
9	October 15	4.7 Annual Plan. - Action: Summary to be added to the back of the next Board report.	Marion Smith / Kylie Parkin	December Meeting
10	October 15	4.8 Consumer Council. - Actions: Organise a meeting to discuss the values and principles document. - Actions: Davida Simpson, Miriama Johnson, Rachael Forsyth, Nicki Lee, Helen Rasmussan, Rangatira - to be approached to attend the reframe and of the Terms of Reference. - Actions: Davida, Miriama and Rangatira invited to attend current consumer council.	Kylie Parkin Kylie Parkin	December Meeting
11	October 15	4.9 Meeting Attendance. - Action: Marie Mahuika-Forsyth to discuss representation with Francois Tumahai and Joseph Mason.	Marie Forsyth	December Meeting

GM UPDATE TATAU POUNAMU

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

TO: **Tatau Pounamu Chair & Members**

SOURCE: **General Manager, Maori Health**

DATE: **5th November 2021**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide a regular update on and overview of key organisational activities and progress. .

The framework used for this report is "Whakamaua – Māori Health Action plan 2020 – 2025" the implementation plan for He Korowai Oranga, New Zealand's Māori Health Strategy.

Whakamaua is underpinned by the Ministry's Te Tiriti o Waitangi Framework, which provides a tool for the health and disability system to fulfil its stewardship obligations and special relationship between Māori and the Crown.

The content has been refocused on reporting recent performance, together with current and upcoming activity.

2. RECOMMENDATION

That the Board:

i. Notes the Hauora Māori Report

Whakamaua – Māori Health Action Plan 2020-2025
WCWCDHB Report Hauora Māori

Priority Area	Key Activities	Progress Update	Risks/Issues
Priority Area 1: Māori Crown partnerships	Tatau Pounamu is actively involved in the completion of a West Coast Health Profile Tē Tiriti Partnership – Consumer Engagement Iwi/DHB Governance partnership established to oversee Mental Health work programmes. Build up a pool of Māori who can provide Māori Health leadership at all levels of the health and disability system.	Profile presented to Tatau Pounamu and actions agreed to have the plan completed. Initiate joint hui to work up the partnership approach. Governance established to oversee MH programmes inclusion of Iwi. Working with Tatau Pounamu and P & C Equity Leads on building Māori Leadership capacity and capability.	Concern resourcing has not been allocated.
Priority Area 2: Māori Leadership	Mana Taurite Workplan – work with the Workforce Equity team to implement Māori Leadership Programme. Hold at least 3 hui for kaimahi Māori to participate in whakawhanauga, share māhī and listen to inspirational key speakers. Facilitate opportunities for kaimahi Māori to access funding through HWNZ to further their education and training.	**Vision**: Grow Māori Leadership at all Levels. Māhī progressing supported by Mana Taurite team. A set of metrics and a timeline has been agreed to run November – April. 2 Maori staff hui held and 1 planned for November Hauora Māori are working with Tipu Ora to provide Whānau Ora training on the West Coast. A Certificate Programme will be delivered early in 2022 with the option for kaimahi to staircase onto the Diploma late in the year. Hauora Māori Staff are funded through HWNZ	• Possible cost/budget allocation. • Covid19 outbreak redeployment of kaimahi involved. • No signoff from WCDHB to continue. A change in Covid19 Levels could affect this provision.
Priority Area 3: Māori Health and Disability Workforce	People & Capability Leads recruited Maori Workforce Plan in place and key initiatives for increasing Māori workforce agreed and implemented. WCDHB Training schedule delivered • HEAT • Te Tiriti o Waitangi • Takarangi	Hauora Māori staff with the CDHB Equity team contributed to the development of the Mana Taurite Draft Work plan. This is now waiting final approval. Te Tiriti o Waitangi training timetabled for Greymouth and Westport has been postponed due to the unavailability of our trainer. Takarangi planned for November at Arahura – 20 registered	Availability of suitable facilitators may delay delivery. Facilitator from the Far North – risk of covid restricted travel.

Whakamaua – Māori Health Action Plan 2020-2025
WCWCDHB Report Hauora Māori

Priority Area	Key Activities	Progress Update	Risks/Issues
		HEAT applied to Oral Health research mahi	Hauora Māori to investigate alternative options to access training, i.e. online through Health Learn.
	Recruitment Policy implemented and embedded across the DHB	Mana Taurite to lead education with Hiring Managers.	
	Kia ora Hauora Programmes delivered.	Dates for the Kia ora Hauora Rangatahi Placement and Exposure programmes have been timetabled for 2022.	A change in Covid19 Levels could affect this provision.
Priority Area 4: Māori Heath Sector Development	Support Poutini Waiora to develop a Primary Kaupapa Māori Mental Health Service.	Poutini Waiora awaiting service specs from MoH. Clinical MH FTE appointed in Poutini Waiora	Recruitment challenges.
	Support Poutini Waiora to fully stand up an accredited vaccination programme allowing them to manage vaccination from end to end.	Poutini Waiora progressing their vaccination status and working through accreditation.	
	Partner with Poutini Waiora to develop the Pae ora o Tē Tai Poutini Model of Care.	Focus sessions held with Clinical Leads. Consultant working up the model to present back to steering group. Aligning with Rural Generalist Model. Hui planned	DHB workforce understanding the model and their role in bringing in to life. No Kaiawhina workforce to implement the initiative.
	Pilot Rā Whānau – free health check for 50+	Slow progression, clinical lead has been identified. Will require dedicated Kaiawhina as a core component of the workforce.	
	Pilot Mana Wāhine Clinics – Breast and Cervical screening for Māori and Pacifica	In partnership with Breastscreen South, Poutini Waiora and our WCDHB Cervical Screening team clinics have been scheduled for November – innovative approach.	
	Hāpū Wānanga enhanced	Funding received through Commisioning Agency to enhance current hapu wananga programme facilitated by Poutini Waiora.	
	Māori Smoking Cessation plan revised and updated	**Plan revised and updated**. Working with Heath West Coast, CPH and Tobacco Free Coalition Group re the implementation plan. National Vaping in Schools survey pending and Grey High Survey completed prior to lockdown. Results/analysis pending. Smoking cessation Practitioners continue to be accessible to Māori clients in a range of locations and settings.	A change in Covid19 Levels could affect this provision.

Whakamaua – Māori Health Action Plan 2020-2025 WCWCDHB Report Hauora Māori			
Priority Area	**Key Activities**	**Progress Update**	**Risks/Issues**
	Long term conditions prevention and management initiatives agreed on and in place. First 2000 days has strong equity focus.	Maori inclusion in steering group and in the community consultation.	
Priority Area 5: Cross Sector Action	South Westland Psychosocial Response Disability Steering Group Cross-govt COVID-19 response to mitigate the impacts of COVID 19 on whanau, hapu, iwi and Maori communities		
Priority Area 6: Quality and Safety	Build the capacity of Māori providers to participate in the WCDHB Telehealth project. Work with P&C Equity Leads to design and implement a programme of work to address racism and discrimination in the health system. Deliver Health Equity Assessment Tool (HEAT) across the system as required. Implementation of the Health and Disability service standards.	Co-ordinating a hui with Poutini Waiora and DHB Maori kaimahi to understand the opportunities for Maori. ISG working with Maori Provider to ensure they have the required hardware and licensing for Microsoft teams. Applying a diverse and inclusive lens over the mahi undertaken by the Equity, Recruitment and People Partnering team has been identified as a BAU activity for the Equity Leads. Programme for HEAT training will be agreed with Service areas for delivery early 2022. Nga Paerewa Health and Disability Standards has been completed and a gap analysis is being undertaken.	Capacity of the Provider to participate.
Priority Area 7: Insights and evidence	Bowel Screening Equity for Maori Oral Health	Contract kaupapa Maori services to engage whanau in the screening programme and incorporate research process to evidence difference in approach. Partnering with South Island Workforce Development Hub to trial a Kaiawhina led model of intervention, applying fluoride to children's teeth bi-annually in the home.	
Priority Area 8: Performance and Accountability	Dashboard development across services	Still in development, needs input and refining	

Whakamaua – Māori Health Action Plan 2020-2025 WCWCDHB Report Hauora Māori			
Priority Area	**Key Activities**	**Progress Update**	**Risks/Issues**
COVID Response & Recovery	Working with iwi providers, resourcing for communications, manaaki, vaccination services, blended team approach (DHB primary care and iwi providers), locality specific, and whole of whanau approach.	Primarily working in partnership with the DHB. Developing contract with Poutini Waiora to enable them to reach whanau in the way that works for them. Ensuring lessons learnt from vaccination rollout are informing the Managed & Self Isolation and managing covid in the community planning.	
Health & Disability Sector Review	Assessment tool completed Transition Plan completed IMPB establishment process understood	**Establishment of IWI Māori Partnership Boards (IMPs)** Tatau Pounamu members undertook a MoH self-assessment to identify member skill/capacity levels and Hauora Māori team are supporting the Chair to create an Establishment Plan which will identifying tasks IWI need to perform to form the new IMPB. Ideally the Board will be formed by April 2022 latest so that work can be done to recognise the Board within legislation from 1 July 2022.	
Emerging Initiatives	Social Equity Adjustment Policy/Protocol for Equity in Planned Care (non-acute services)	Initial hui planned with clinical leads to better understand the opportunities.	

TATAU POUNAMU ADVISORY GROUP
HEALTHY LIFESTYLES SERVICES UPDATE

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
Tatau Pounamu Manawhenua Advisory Group

SOURCE: **Planning and Funding**

DATE: **Friday 15 October 2021**

Report Status – For:	**Decision** ☐	**Noting** ☑	**Information** ☐

1. **ORIGIN OF THE REPORT**

Healthy Lifestyles Update is a regular agenda item.

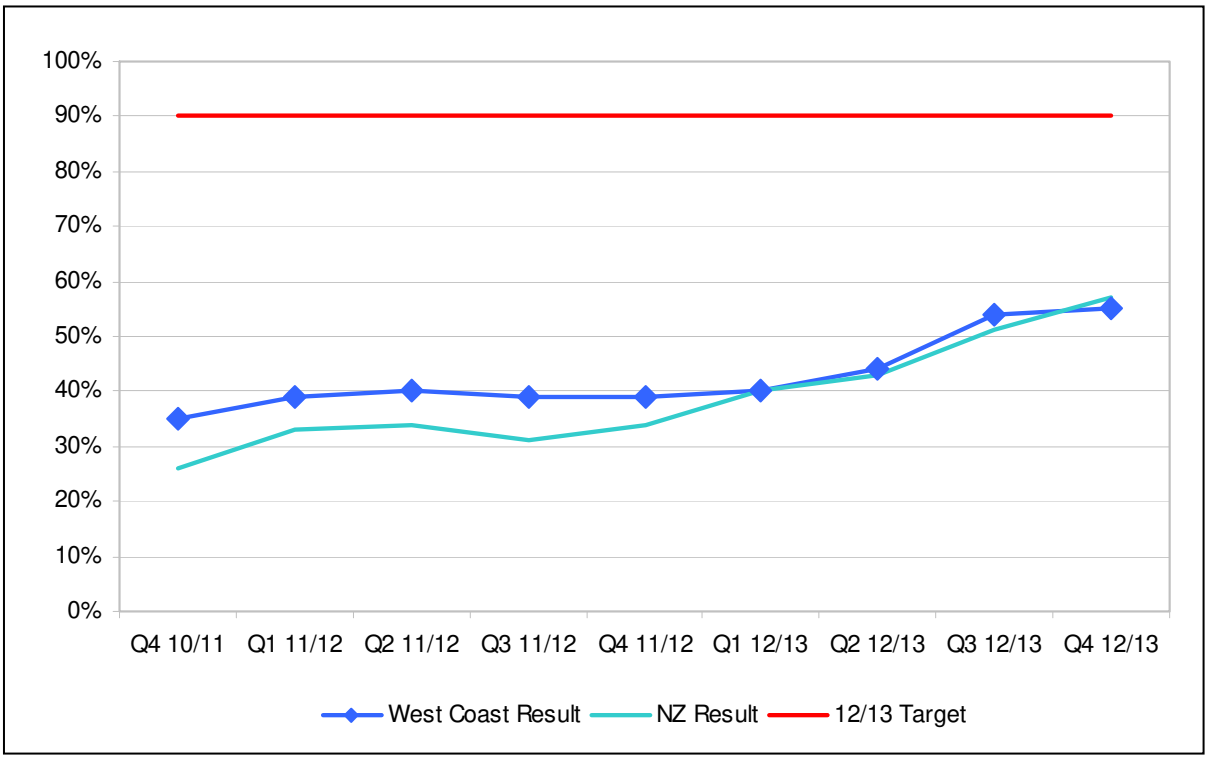
2. **SUMMARY**

The report includes an update on:

- Smokefree Health Targets – Primary and Secondary
- Green Prescription

3. **DISCUSSION**

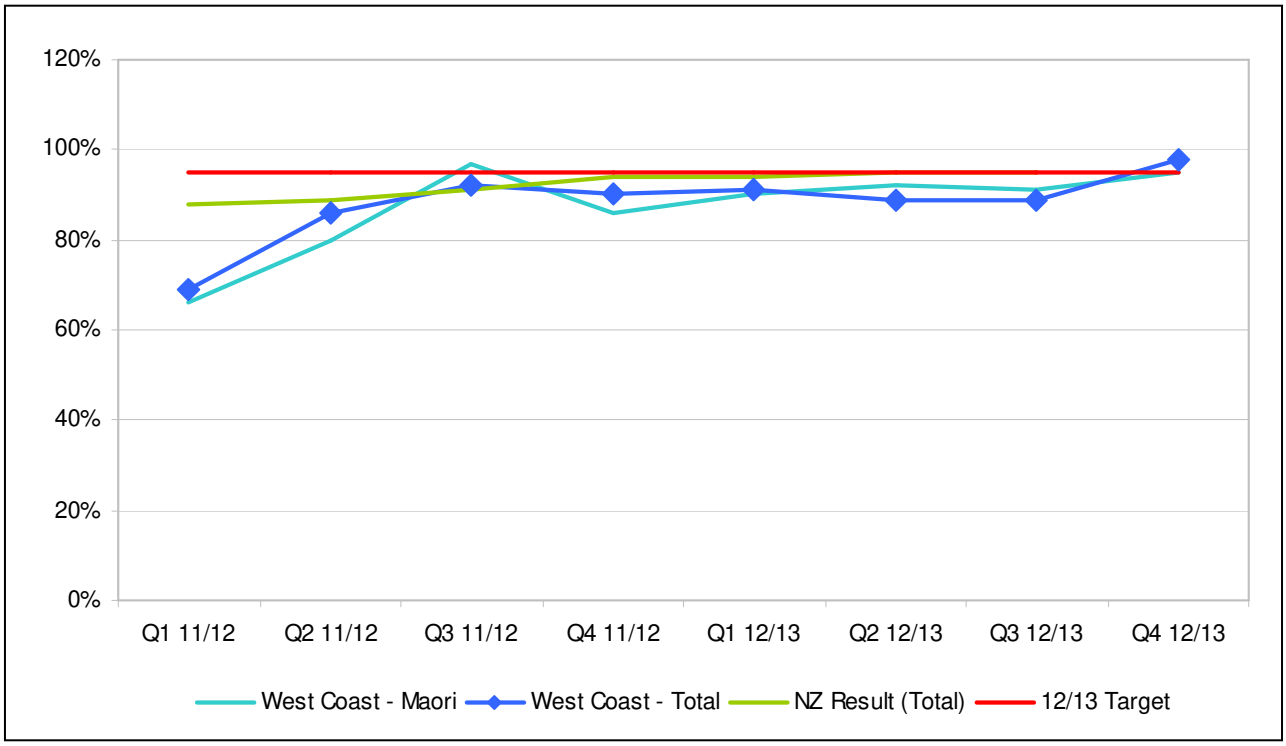
Primary Smokefree Health Target: 90% of smokers attending primary care given advice & help to quit



Quarter 4 Result: Total – 55%, Maori – 55%

Preliminary results from MoH show a marginal increase in performance against the primary care smokefree health target this quarter, with 55% of people who smoke attending general practice, offered advice and support to quit. Work is continuing on enabling the Clinical Audit Tool to be installed in the DHB Medtech server configuration; this will support clinicians to improve data capture. The PHO has continued to include coding and data entry training as part of orientation for all new practice staff, along with updates for identified current staff.

Secondary Smokefree Health Target: 95% of hospitalised smokers given advice & help to quit



Quarter 4 result: Total – 95%, Maori – 98%

West Coast DHB achieved the secondary care smokefree health target for Quarter 4, with 95% of patients who smoke offered advice and support to quit (and 98% of Māori). Smokefree staff are working to maintain a clinical focus around the health target, for example running a Quit Card refresher training, which encourages staff to provide Quit Cards on discharge from hospital to take the idea of 'better help for smokers to quit' further than the initial ABC.

Green Prescription:

As part of the larger 2013 Diabetes Budget package, the Ministry of Health have indicated an increase in funding for Green Prescription referrals over the coming four years. For the 2013/14 year, this is an increase from 360 to 500 referrals on the West Coast. Green Prescription has been identified as a key component to help slow or prevent the progression of pre-diabetes and diabetes, as well as a way to support the active management for those who already have diabetes.

TATAU POUNAMU ADVISORY GROUP
MANA AKE – MENTAL HEALTH AND WELLBEING IN SCHOOLS

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
Tatau Pounamu Manawhenua Advisory Group

SOURCE: **Mana Ake - West Coast Project Team**

DATE: **Friday 9 November 2021**

Report Status – For:	**Decision** ☐	**Noting** ☐	**Information** ☑

1. **ORIGIN OF THE REPORT**

Mana Ake – Mental Health and Wellbeing in schools.

2. **SUMMARY**

The report includes an update on:

- What is Mental Health and Wellbeing in Schools Co-Design
- Consultation Plan
- How and when we will report back to Tatau Pounamu

3. **DISCUSSION**

The Government announced in April 2021 its commitment to funding a mental health and wellbeing programme for primary and intermediate school children. The West Coast was selected as one of the five new district health board (DHB) areas to be part of the first tranche of creating a tailored programme.

Mana Ake was established in 2018 in Canterbury and Kaikōura in response to the trauma some children were experiencing after the earthquakes in 2010/2011 and 2016. Mana Ake provides resources and support for teachers to help their students who are dealing with things like bullying, parental separation, grief and loss.

Embarking on the co-design process in an innovative way that leverages off the critical successes of Mana Ake, the Project Team is eager to create space for discussion and understanding that will result in a robust Plan for our tamariki.

The Project Team that is made up of both health and education will:

- Facilitate and support collaboration
- Engage the education sector, community, iwi, whanau
- Develop and support the infrastructure

Development of a co-designed Plan will be informed by community consultation utilising the below methods, please refer to the below table for the details of the consultation Plan

1. **Written feedback**: a survey with set of targeted health and wellbeing questions will be circulated to gather initial responses via Survey Monkey. This platform will allow for the comparison of responses on a community and school type basis. Canvassing results from a large population is critical on the West Coast as:

(a) the geographical area of the West Cost is equivalent to the distance from Auckland to Wellington encompassing small rural communities and larger townships. Locality needs, and support access varies greatly between these areas;
(b) areas of the West Coast have been severely impacted by differing significant events such as floods, rapid Covid-19 related economic decline and large unemployment in industries such as forestry and mine closures; and
(c) education of years 1-8 students on the West Coast occurs in a variety of English and Maori medium primary schools and includes area schools, secondary schools, correspondence school and home schooling. Education facilities are both rural and township based across the region.

2. Targeted Consultation:
Targeted consultations will be undertaken with select focus groups. Education providers and schools will be selected based on their rurality, low decile rating, high portion of Maori and Pacific students, home or alternative education providers, and highlighted by members at the co-design workshops as having a high portion of tamariki that are not engaged.

Early involvement is being sought from the West Coast Primary Schools Principals Association through a virtual forum organised by the New Zealand Principals Federation (NZPF) and at their annual conference and the local iwi Komiti Matauranga (education committee) in their forthcoming meetings.

3. Collective Co-design workshops:
We will run three co-design workshops targeting the Northern, Central, Southern areas (intended to be kanohi-ki-te-kanohi) with stakeholders from across the region. These stakeholder group will include Education Leadership, SENCOs, Maori and iwi representatives, NGO Providers, General Practice, Specialists in child and adult education and health, Public Health Nurses, Whanau, and other government organisations such as Police, Oranga Tamariki, Ministry of Social Development, non-government organisations, community and focus groups. These co-designed workshops will build on the initial stakeholder consultations held in May and July on the West Coast.

Focusing on a strength-based approach, with the aim of achieving a transformational change that moves

From	To
• People struggling	• Mental health and wellbeing
• Mental illness • Impact of trauma	• Prevention and early intervention
• Specialist services as preferred response	• Working together • What's best for tamariki and their whanau

The Project Team will report back to Tatau Pounamu throughout the Planning process to seek Tatau Pounamu's feedback that will inform the shaping of the Plan.

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

School-based Mental Wellbeing Services
Co-design Plan Outline

How will this be achieved	Target group & purpose of involvement	Milestone
1. Ensuring the voice of tamariki and whānau are included in the co-design process.		
Written feedback	A **Survey** will be sent to schools for provision to whanau, teachers and support staff to gain valuable feedback from the students to inform the co-design process.	Invitations to participate in a survey will be emailed out at the end of September.
School visits to targeted schools. There are 30 schools in the West Coast region. Schools have been chosen on the basis that: ✓ They address one or more of the focus areas identified in the Service Agreement ✓ They contain a high population of groups statistically impacted by health and wellbeing issues; and/or ✓ Represent a cross-section of schools on the West Coast. School visits will seek input from staff, whanau, school representatives and/or tamariki.	**<u>Largest Schools on the West Coast:</u>** **Hokitika Primary School**: Hokitika has the highest population of Maori on the West Coast and the largest Maori medium population. The Primary School is a decile 5 and feeds into Westland High school. This High school has the highest portion of stand downs of the Region (as per Stats NZ) and ongoing challenges with students has been reported by school Management. **Greymouth Main Primary School**: Greymouth Main Primary School is the largest school on the West Coast and has two bilingual classes and the largest Pacific Island population. **Westport North School:** Westport North School has the highest population of Maori in the Buller District. It has a bilingual class and has identified disparity for Māori children in reading, writing and mathematics and for boys in writing. Buller has faced significant challenges with the recent Floods and Covid-19 lockdowns occurring within weeks of each other. It has been identified as having high mental health and wellbeing needs.	During the months of October and November, we will consult with the schools highlighted by travailing to schools and meeting with Principals, SENCOs, whanau and tamariki to identify the need and gaps as they see it. We have collaborated with the Ministry of Education Learning Support specialists to provide advice on the best way to engage with Primary School aged children to get the most true and honest response.

How will this be achieved	Target group & purpose of involvement	Milestone
	Rural School and Lowest Decile Rating: **Karamea Area School** is at the top of the West Coast region. The nearest town is Westport which is 100km South through an unforgiving stretch of road, there is only one way in and out of Karamea which leaves the area at high risk of isolation. The school has a decile rating of 4. **Haast School** is a very small, rural primary school in an isolated area of South Westland. It caters for students in Years 1 - 8. **Maruia School**: is on the cusp of the West Coast Education boundary, located at the entrance to the Lewis Pass. It caters to year 1-8. **Decile 3: Runanga, Cobden, Granity Primary Schools** are the lowest decile schools on the West Coast One class of each year group from schools will be selected from the below: ***This list may change after results of written feedback have been gathered.***	

How will this be achieved	Target group & purpose of involvement	Milestone
Whanau consultation: Whanau will be invited to participate in the written feedback, Collective Consultation and Target Consultation sessions.	**Whanau** hui will be held at a selection of the schools listed in section 1. A wrap around, whole of system approach is being sought and their input is required to do this. Schools will be also be asked to identify whanau who may have had mental health or wellbeing issues.	During the month of October and November.
Non-mainstream educators: Capture the voice of whanau & tamariki who are outside of mainstream education channels.	**Home schooled tamariki:** Two whanau have been approached to provide input. They identify as Maori and Pacific Island and have home schooled for health and wellbeing related reasons. Other potential whanau to be sourced through the Home School Parents Association	Preliminary discussions with the whanau to arrange a time and date for consultation are underway. Time and dates to be confirmed once the consultation content is finalised.
	Unengaged: Whanau and tamariki who are not engaging in mainstream education and/or are classified as truant can be from the most at-risk group for mental health related issues.	Contact made with Greymouth Alternative Education provider. Consultation requested to occur in October. Tamariki in this cohort are usually outside the cohort for the project however the learnings from this organisation on why tamariki come to their attention will be valuable Consultation will also be held with Te Kura who provide educational services and support to a range of students in years 1-8 across the DHB area. Discussions with whanau ora worker to coordinate involvement of potential whanau and tamariki identified as “truant” or disengaged ongoing.
2. Ensuring school representatives from low socioeconomic, rural schools and kura kaupapa are included in the co-design and/or governance group		
Collective Co-design workshops:	**Three co-design workshops** (intended to be kanohi-ki-te-kanohi) with stakeholders from across the region. These co-designed workshops will build on the initial stakeholder consultations previously undertaken on	The co-designed workshops will be held during the early part of **term 4 2021** Invitations to:

How will this be achieved	Target group & purpose of involvement	Milestone
	the West Coast. The workshops will be facilitated by the Project Team **Northern**: Westport for schools and stakeholders in the Buller area including Reefton Area School; **Central**: Greymouth for schools and stakeholders in the Mawhera and Hokitika areas; and **Southern:** Hari Hari for schools based in South Westland.	• Principals • SENCOs • Maori and iwi representatives • NGO Providers • General Practice • Public Health Nurses • Education specialists • CAF and Mental Health Specialists • Whanau Ora • Sport NZ • Attendance Service • Whanau • Government organisations: - MSD - Police - Oranga Tamariki
Consult with Principals and Senior Leadership Teams and educators from West Coast schools. This will be Captured at the school visits described in section above, collective consultation sessions and written survey/ feedback requests described in.	**West Coast Primary School Principals**: capture basic feedback from a wide cross-section of schools. **School based educators**: Initial engagement already started Principals, Senior Leadership Teams and whanau of rural schools.	Ongoing discussions with Principals through the various associations across the region. Sharing of information and focus group discussions.
Targeted feedback from **whanau and tamariki who identify as Maori and are connected to local Maori medium** classes.	Input from bilingual units is sought as there are no kura kaupapa on the West Coast.	To be consulted during school visits and asked to provide written feedback.
3. Plans to ensure the engagement of and partnership with Iwi and Hauora Māori, at all levels and in all stages of the co-design process		
Whanau hui with bilingual units	Hokitika Primary and Grey Main Primary School.	Hokitika Primary School will confirm a time in the next few weeks. Grey Main Primary School to be contacted.
Seek representation and engagement from the Iwi **Komiti Matauranga**.	The Iwi Komiti Matauranga spearhead education initiatives on the West Coast. We will seek their input & involvement in the Plan development.	Komiti has agreed to allow us to Present and will put us on the next meeting's

How will this be achieved	Target group & purpose of involvement	Milestone
	We hope that more regular involvement from the local marae based iwi education committee is obtained. They are being approached to nominate a representative or contact person to work with the Project Team. We will otherwise agree to provide regular updates and seek feedback as the Plan takes shape.	agenda and will advise when that is.
Inclusion of **Rangatahi Komiti** to capture the youth iwi voice.	The local marae based youth committee has been approached with a view to involving them in the Plan development. The Rangatahi Komiti have already hosted a two-day suicide prevention hui and are engaged with mental health and wellbeing initiatives for youth.	A formal request to attend the next meeting will be made in September with a view to attending the October meeting.
Engagement with local Maori health providers.	Poutini Waiora and Te Ha o Kawatiri are aware of the Plan development. They will be and have been invited to participate in written feedback, collective consultation and targeted consultation each as described above.	Formal requests for involvement to be made in September. Written Feedback requests to be provided in October.
Plans to engage other service providers and stakeholders		
Collective Consultation hui and written feedback will be sought from service providers and other stakeholders.	Two initial huis have been held with a cross section of whanau and child educators, child and your workers, government agency representatives, NGO's, health workers, whanau ora workers and whanau.	Date for the next consultation session to occur in October.

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
Tatau Pounamu Manawhenua Advisory Group

SOURCE: **System Level Measures Improvement Plan – Alliance Leadership Team**

DATE: **Tuesday 9 November 2021**

Report Status – For:	**Decision** ☐	**Noting** ☐	**Information** ☑

1. **ORIGIN OF THE REPORT**

System Level Measures Improvement Plan (**SLMIP**) – Alliance Leadership Team **(ALT)**

2. **SUMMARY**

The report includes an update on the System Level Measures achieved for the 2020/2021 financial year.

3. **DISCUSSION**

Four out of the six System Level Measures from the 2020/21 SLMIP were achieved for the year:

(a) **ASH Rates 0-4 Year Olds**: Reduction of the 3-year average ratio between ASH rates for Māori children to below 1:1.23 was achieved with rates being 1:1.06

(b) **Acute Hospital Bed Days**: The milestone target of reduction of the Acute Bed Day Rate for Māori to below the current 3-year average rate of 331 per 1,000 of population and continuing to ensure the equity gap between Māori and total population is either negligible nor favourable to Māori was achieved. Acute Bed Day Rate for the year ending March 2021 was 147 for the total population and 144 for Māori.

(c) **Amenable mortality**: The milestone for this measure was achieved. The current downward trend in amenable mortality with an anticipated rate, or close to, 70 amenable deaths per 100,000 people by June 2023 was maintained.

(d) **ASH Rates 0-4 Year Olds**: Reduction of the 3-year average ratio between ASH rates for Māori children to below 1:1.23 was achieved.

The two System Level Measures not achieved from the 2020/21 SLMIP were:

(a) Youth access to and utilisation of youth appropriate health services: The milestone for this measure was to maintain a downward trend for self-harm hospitalisations to a rate of 32 per 10,000 population and continue to ensure the equity gap between Māori and total population is negligible. As at March 2021, the total population rate per 10,000 was 47.1 with the rate for Māori being 49.3. The milestone has not been achieved with a sharp increase for self-harm hospitalisations evident as against 2020 figures and the equity gap widened for Māori.

(b) Babies living in smokefree homes: The milestone of reducing the equity gap between Māori and Non-Māori babies living in a smokefree home to less than a three-year average of 12% was not

achieved. The equity gap has increased and, as at March 2021, is 17.7%. Whilst a growing number of Māori pepi are living in smokefree homes (approximately 2% more 2020) the Alliance is focussed on significant change.

The challenge for ALT will be driving results and systemic change in 2021/22. Focus will be on ensuring the SLMIP targets are well socialised at all levels of the organisation, amongst health providers, stakeholders and those responsible for outcome delivery. Any agreed ALT plan(s) on how best to monitor and assist in achieving the SLMIP outcomes will be disseminated and discussed as appropriate.

Report prepared by: Davina Ruru, Acting Team Leader, Planning and Funding (on behalf of the West Coast Alliance)

Report approved for release by: Kevin Hague, Chair, Alliance Leadership Team

Commissioning for better outcomes and improved stewardship of the health and disability system

Introduction

The way we commission in the health and disability system impacts whānau wellbeing and equity and we must do better. Outcomes for Māori and other poorly served groups won't change unless we change the way we trust, think, act, fund, deliver and assess outcomes when we commission.

Ministry of Health's commissioning frameworks

As part of delivering a key objective under Whakamaua, responding to the WAI2575 and Health and Disability System Reform (H&DSR) recommendations, the Maori Health Directorate has been leading the:

- **Commissioning for Equity and Wellbeing Framework** to:
  - help guide the Ministry of Health in its current role as commissioner, and its future role (along with the Māori Health Authority) in monitoring Health NZ and the MHA's commissioning performance and results. This includes understanding key enablers (workforce, data and digital, performance monitoring and continuous improvement).
  - provide guidance to the Public Health Agency on how the mix of levers (regulation, policy, commissioning and monitoring and evaluation) can be aligned to create stronger interventions
- **Pae Ora Commissioning Framework** to guide current commissioning and provide potential insights for the Māori Health Authority and Iwi Māori Partnership Boards to help:
  - improve the commissioning, and co-commissioning of health investments in collaboration with Health NZ and wider social sector agencies
  - remove barriers to entry and sustainability for kaupapa Māori providers
  - improve the capacity and capability building of kaupapa Māori providers
  - understand what is needed to align work across the wider social sector to improve outcomes, including cross-sector commissioning, investment in provider capacity and capability and strategic (rather than reactive) provider market shaping.

Principles and evidenced-base

These two commissioning frameworks share the same DNA, are grounded in Te Tiriti o Waitangi principles and draw on the insights from Puao-te-Ata-tu, Te whare tapa whā, whānau ora and the Wai 2575 Health Services and Outcomes Kaupapa Inquiry. Te Puni Kōkiri's Te Piringa research has also shaped these Frameworks, with the aim of bringing the Whānau Ora vision into primary and community care. (See Appendix one).

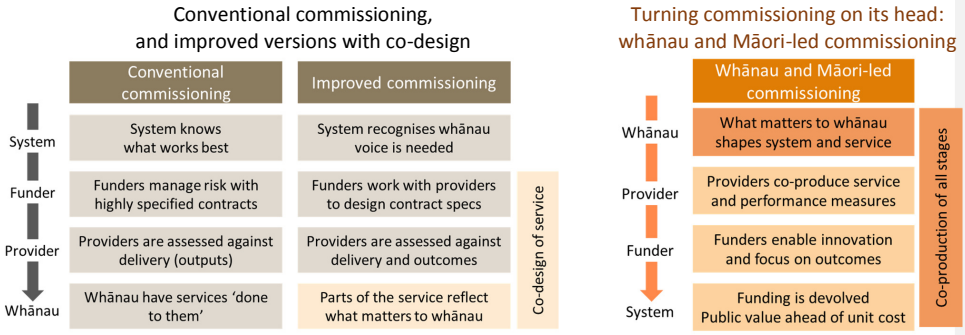
Alignment to strategic context

These frameworks use the same commissioning cycle stages and language (eg sourcing and investing, instead of procuring) as the Social Sector Commissioning work programme, to help with future cross sector work. The frameworks set out the key shifts needed at each stage of the commissioning cycle to embed te Tiriti principles and respond to the WAI2575 recommendations.

These Commissioning Framework have two key aspects:

- there is a primary focus on what works for people and whānau, rather than prioritising what the system does; and
- they support cross-sector work, and the focus on enduring improvements for people, whānau and communities embedded in the Public Services Act (2020) and the Public Finance Act wellbeing amendments.

Figure 1: Shift from conventional, to improved, and then whānau and Māori-led commissioning

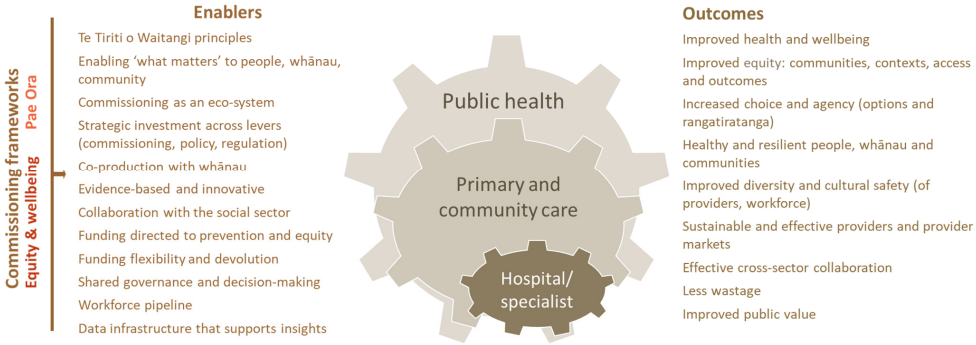


A commissioning framework that can be used across all investments

A benefit of the commissioning frameworks developed by the Ministry is that they can be applied to public health, primary and community care and health and specialist services, noting there will also be specific requirements for each (eg a different order of capital investments for hospital and specialist services). This could help provide a common commissioning approach to embedding Te Tiriti principles and a focus on more enduring and broader health and wellbeing outcomes across different parts of the health system. Going forward, the common approach could support insights and collaborative approaches to investments and awareness where other levers are needed.

Appendix 2 shows how the framework can also be used for planning investments across the life-course, for different types of investments, and across the broader social sector.

Figure 1: Commissioning frameworks for the whole health system, with shared enablers and outcomes



Guide action – and accountability - over time

Appendix three shows the different participants in the commissioning system, and how they can mature in their commissioning practice over time. This can be supported by development plans, linked to good practice guides, tools, templates and other resources. Appendix four provides an overview of the key commissioning cycle stages, the key shifts needed at each stage, and who is accountable for enacting and embedding these shifts in the short and longer-term.

Status

The commissioning frameworks have been a collaborative development across the Ministry and with sector agencies, and are one of the seven flagship programmes for the Ministry in response to the H&DSR.

The Ministry's DDG level Commissioning and Funding Group engaging with the TU, the Funding and Commissioning ELT and Outcomes and Equity ELT have endorsed these Commissioning Frameworks for use across the Ministry. Commissioning groups (eg Population Health and Prevention and Early Years Programme) have been engaged in testing and applying the framework to their work. The Pae Ora commissioning framework has been reviewed internally including with the Māori Health Directorate and external commissioners are interested in using and testing the approach.

What's been shared with the TU

An early draft of the Ministry's Commissioning for Equity and Wellbeing framework, and a partially done detailed guide for Pae Ora Commissioning have been shared with the TU team leading their commissioning work. The Ministry can share updated versions with the TU.

Overview of what's needed in commissioning frameworks from the Ministry of Health's perspective (based on evidence and work to date[1])

Case for change	Useful to start with the case for change, eg: - inequities that exist for different groups and localities, and an assumption of an equal starting point (which creates and reinforces systemic bias) - the need to identify and address inefficiencies and system waste from the wrong types or timing of responses (and invest in the data infrastructure, evidence and insights to improve investments) - the default to service responses, when other interventions (or levers, eg policy or regulation) could be more effective
Te Tiriti grounded and evidence-based	• Be grounded in te Tiriti and the application of the Wai 2575 Hauora principles • Support commissioning processes and investments that are grounded in evidence on what works for people, whānau and communities to produce enduring change
Systems approach	• Take a systems-approach, considering commissioning alongside other levers (policy, regulation), and the health system alongside the broader social sector
Commissioning that enables people, whānau and communities	• Support a fundamental shift away from 'doing to' and 'doing for' people, whānau and communities. Commissioning instead starts with a 'capability approach' and seeks to enable communities, whānau and people to exercise choice about the outcomes they want and what they will do to achieve these.

[1] The commissioning frameworks have been based on a review of commissioning literature, and what works/ is needed to improve outcomes for Māori, Pacific people, people with disabilities and other groups not well served by mainstream services. Ideas have been tested in workshops across the Ministry of Health, as well as with social sector agencies, DHB commissioners, Māori and other providers and mana whenua, with a focus on what is needed to enable mātauranga Māori and system change. A series of case studies have been produced to capture insights across a broad range of services, system changes and investments, including flexible funding, community development, equity-informed delivery models, innovation procurement practices and IT infrastructure. (See Appendix 5. Several learning partnerships have also been developed, to test and refine understanding of effective commissioning, and system conditions that act as enablers, barriers or constraints. (See Appendix 6).

Builds for the future	• Commissioning's purpose and processes aim to strengthen the wider 'social system' in communities, so communities are ready and equipped for current and future challenges and opportunities • People, communities and providers are more resilient and flexible as a result of the commissioning purpose and processes used
Inspire new ways of thinking, working, investing, assessing	• System and service purpose is shaped by 'what matters to people, whānau and communities' • Inspire new ways of thinking, working, investing, delivering, assessing and improving • Allow time in the commissioning process for collaboration, including understanding what enablers are required • Use a life course approach and support key stages of transition and development in people's lives, such as young people
Shows opportunities from the new H&DS	• Demonstrate how the new H&DS, and each entity, will use commissioning to improve health equity and outcomes
Changes the system conditions: barriers and enablers	• Identify and address system conditions that act as a barrier to good commissioning, for example: - disease and deficit mindsets - low value contracts from multiple funding sources for primary and community care; the provider version of '20 contract managers up their driveway' - funding categories and appropriations that create silos/ prevent flexible responses (internal and centrally set) • Understand enablers (contract and provider data systems[2], evidence of what works, workforce pipeline) and build a road map to support implementation through to a mature system
Actively develops providers and markets	• As part of good stewardship, ensure provider capability and market shaping is pro-active and strategic, and contributes to diversity and equity
Has technical guides	• Develop technical guides for commissioning for hospital and specialist services and primary and community care • Show how public health can be improved through commissioning these services, and how these services can provide insights on where public health responses are needed
Enables Māori and community leadership and governance	• Iwi Māori Partnership Boards need to be enabled to be effective when influencing investment decisions, and reflect whānau voice and choice • Commissioning progressively shifts leadership to the community, enabled by good insights, evidence of what works, prioritisation and investment processes
Uses planning and accountability to drive improvements	• Clear pathways to influence planning and accountability documents eg the Health Plan • Use accountability processes to support and drive quality improvement
Uses a mix of communication tools	• Develop comms, case studies, videos and other collateral alongside culture change and collaboration to support implementation.

[2] There is no central database that connects contracts to providers within the Ministry of Health, limiting the ability to understand where investments have been made. There is also no current system that connects investments to outcomes.

Expanded view

Why change?

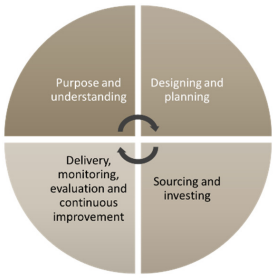
Our work in the commissioning space suggests it is helpful to clearly set out why commissioning needs to change, and to then track what is being done (by whom) to enable and/or enact the changes needed. We've found summaries

Inequities - in communities, contexts, access and outcomes	• Inequities in: - communities and contexts (eg lack of infrastructure, poor quality housing, lower education and employment opportunity, lower wages, travel time) - access to timely, quality health interventions and support and in outcomes - outcomes (from the combination of broader determinants of health and a health system that poorly serves some groups). • Assumption that there is a level playing field, which makes the current system prone to inherent bias and systemically racist decisions about service type and design
Low evidence base	• Low evidence base of what works in Aotearoa New Zealand and with our diverse populations • Waste in system through investments that don't produce value (particularly BAU, which often goes unassessed, and evaluations that only focus on new services)
Effective innovations not embedded	• Innovations that do work are either not evaluated or not supported through to embedded practice • Limited investment beyond pilots to embed, replicate or spread effective practice
Narrow understanding of commissioning	• Commissioning is seen as procurement, not an end-to-end process • Commissioning defaults to buying new 'services' and misses other types of investment including system change
Commissioning not connected to other levers	• Commissioning developed in isolation from other levers (policy, regulation) and other approaches to add value and efficiency such as providers collaborating to achieve shared outcomes
Inward looking	• The majority of the social and economic determinants of health fall outside of the Health sector's direct influence, and requires greater cross-sectoral collaboration to influence and improve outcomes • Commissioning is often inward looking, to usual health players, and not connected to the broader social sector
Need to take account of broader context	• Socio-economic inequities intersect with geographic features and built environment/ infrastructure, creating 'post-code' lotteries for some services
Ad hoc approach to providers and markets	• Provider capability building and market shaping is ad hoc, not strategic • Accreditation is an increasing requirement for other Government contracts, and there is risk some providers may miss out on broader wellbeing contracts. (Accreditation could also shut out smaller, innovative providers).

What is commissioning, and what is needed to do it well?

- Definition of commissioning – that includes all the levels (strategic, service, capability of providers and markets)
- Benefits of commissioning across the ecosystem (service users, whānau, community, providers, funders, system etc)
- How commissioning embeds Te Tiriti Principles (and how these principles also reflect evidence on what works to improve individual and population level outcomes)
- The evolution of commissioning from an individual and service focus to an eco-system and population focus (with broader and more enduring wellbeing outcomes)
- Commissioning cycle stages that align to the social sector commissioning work[3], to help support increasing cross-sector collaboration:
  - Purpose and understanding
  - Designing and planning (including gathering evidence for what will work and prioritisation for highest impact including around equity and meeting Treaty obligations)
  - Sourcing and investing (including using Kaupapa Māori methodology and providers)
  - Delivery, monitoring, evaluation and continuous improvement.

Figure 2: Commissioning cycle, matched to social sector commissioning (collapsed categories)



- Commissioning levels: stewardship, strategic, national, regional, local, individual
- Commissioning types: contracted services, capacity building (providers, whānau, community) and choice (individualized funding)
- Prioritisation and investment strategies (including the 'big health and wellbeing issues' prioritised, along with programmes, then interventions).
- Decommissioning.

How commissioning needs to change

- Commissioning seen as part of an eco-system, with the framework supporting systems thinking, and right system conditions and enablers.
- Maturity model used to show aspirations and stage along the maturity pathway (see Appendix 3)
- Commissioning is supported by other levers (eg policy, regulation, performance monitoring)
- Commissioning needs to encourage innovation and improvement within existing sourcing, procurement and accountability requirements, as well as identifying where these requirements need to be challenged and changed (eg lighter business cases for prototyping, reducing potential bias from accreditation, or AOG panel criteria and processes).

[3] https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/information-releases/the-future-of-social-sector-commissioning/appendix-to-cabinet-paper-the-future-of-social-sector-commissioning.pdf

Enablers for commissioning

Our evidence suggests that the commissioning framework will include the following types of enablers.

Commissioning as part of an eco-system	What's needed is a framework with commissioning in an eco-system: - with a mix of commissioning levels and types - reliant on provider capability, diversity, sustainability and market shaping - requiring cross-entity and cross-sector co-commissioning and investment
Focus on what matters to people, whānau and communities	• A framework that prioritises understanding whānau and community needs, strengths, aspirations, preferences and context • Outcomes reflect what matters to whānau • Whānau and communities are seen from a strengths and capability lens
Focus on longer-term outcomes	• A framework that helps shift thinking from health system-determined, to whānau-led, and health system enabled • The importance of cross-sector collaboration to address social and economic determinants of health influences thinking, design, delivery and investments
Providers treated as trusted and capable	Providers are seen as capable and: - commissioners value their insights - contracts are high-trust, permissive and support sustainable delivery - performance monitoring is designed to support continuous improvement
Those 'on the ground' shape performance measures	• Clinicians and providers shape performance measures, to track variance in outcomes and to support continuous improvement
Funders create an enabling environment	• Funders work to create enabling environments for providers, whānau and communities • Commissioners work from a presumption that providers are trustworthy • Time frames allow relationships with providers and communities to be built and maintained • Commissioning is understood as an end-to-end process, from co-design, co-production, innovation, evaluation and continuous improvement, and provider capability and market shaping • Managers support innovation, and permissive contract arrangements (proportionate to risk)
Commissioning workforce is creative and diverse	• Commissioners receive training and guidance on how what they do and how they work can support better outcomes – for people, whānau and communities, for providers, and for the system • More Māori and Pacific people are recruited, trained and promoted in commissioning roles • All commissioning staff are trained and supported to be creative (and still compliant) within existing requirements, and to consider and then escalate practices which create or maintain bias, so these can be changed
Investments and processes are reviewed for bias	• Potential bias at the point of decision-making are understood, and processes and practices adopted to reduce the risk of bias • Managers and teams review processes, and investment decisions and criteria, to identify and address any potential areas of bias (including accreditation, AOG panels, sourcing and procurement processes)
Innovation is embedded	• Successful innovations are supported through to embedding practice, with sustainable funding and/or community capacity to deliver

System view of costs and benefits	• When developing prioritised investment strategies, taking a system view of costs and benefits to: - include embedding Te Tiriti principles, improving equity as values in their own right - avoid the distorting incentives from focusing on efficiency only (eg incentives to 'cream' low complexity cases and deflect or 'park' more complex one). • A systems view can also help reduce/remove other conditions that drive poorer outcomes, for example part-payment fees for primary care can act as a barrier to accessing preventative services, leading to escalation of problems (particularly when there are no fees for emergency services). Or the lack of 24-hour care for people in mental health crisis due to low service availability leads to the costs being picked up by other sectors, eg Police.
Decommissioning is managed well	• Decommissioning processes are evidence-based, transparent and have lead-in times that allow service continuity, redesign and alternative funding options. • Decommissioning can be hard, and sometimes decisions are reversed due to political or stakeholder advocacy, even when the service is no longer meeting demand or providing public value. Decommissioning can be supported by:[4] - having a clear rationale and seeking consensus on the reasons why change is needed - focusing on public value (the need to direct funding to what produces outcomes) - good governance and clear decision-making processes - early signalling to all stakeholders and good communication throughout - robust risk management.
Data infrastructure supports investment	• Data infrastructure is developed that connects providers, contracts and outcomes and interim solutions (eg excel spreadsheets) are developed.

Opportunities (and risks) following H&DSR

Figure 3 shows current and future commissioners and co-commissioners in the health and disability system, now and from July 2022 (noting that full implementation will likely take 2-3 years).

Figure 3: Key commissioners in the health system – now and from July 2022

Level	Until July 2022	From July 2022	
National	Ministry of Health and it's commissioning directorates	**Ministry of Health** Public Health Agency	**Maori Health Authority**
		Health NZ	
Regional	District Health Boards	Health NZ	**Maori Health Authority**
Local	District Health Boards	Health NZ	**Iwi Māori Partnership Boards**
		Locality networks	

[4] UK National Audit Office guidance on decommissioning.

Some of the key opportunities and risks that would need to be addressed in the commissioning framework are noted below.

Opportunities	• Use a Te Tiriti grounded and evidence-based framework that can be applied across the whole health and disability system, which starts from 'what matters to whānau and communities', with additional advice tailored to: - hospital and specialist services eg future demand and prioritised capital investments - primary and community care (eg understanding the impact of fees or other potential to timely service access, working strategically with the broader social sector to support community and whānau development alongside the more common service provision approach - public health, in particular the focus on population health and determinants, which points to much stronger focus on cross-sectoral collaboration, including a more joined up approach to policy, strategy, and commissioning/co-commissioning, or at least integrated/aligned commissioning where agencies ensure that what they are commissioning is complementary • show clear pathways for the different entities to influence planning, prioritising and accountability documents (eg Health Plan) • identify key accountabilities across the commissioning ecosystem (including replacing previously ad-hoc approaches with strategic investment, eg in providers and provider markets) • identify and prioritise investments needed to mature the system enablers, including longer-term investments in workforce, data and digital and health literacy
Risks	• the existing data infrastructure limits insights on interventions, providers and outcomes, reducing the ability to make informed strategic investments (including decommissioning) • the MHA does not have a direct local presence, mitigated through building in the • resources, processes and time to work with Iwi Māori Partnerships Boards • wide variation in Iwi Māori Partnerships Boards' capability, mitigated through additional resourcing for those in embryonic or early stages of maturity • the operational functions delivered by HNZ align may not align with the Ministry of Health's strategic and stewardship setting (managed through the Health Plan) • the Ministry of Health may lack understanding of local contexts and emerging health demand (managed through investment in surveillance, insights and reporting) • have escalation pathways agreed to help bring areas of disagreement to resolution.

Potential barriers to transformation

We'd hope to see the commissioning framework have a clear articulation of the potential barriers to transformation, and ideas of potential barriers are summarised below.

Awareness and commitment	• The need to increase awareness, understanding and commitment to a new way working
Words but not reality	• Using language of transformation, but in practice replicating, or defaulting to, the status quo
Scale of change	• Widespread and simultaneous change, while managing a global pandemic • Based on previous reforms (of a smaller scale, and without a global pandemic) it is likely to take 2-3 years for implementation to be completed, and around 5 years until the changes are fully operational
Low aspirations	• 'Baked -in' reliance on navigators (rather than a more aspirational goal of having a health system that is easy to use, and investing in health literacy. Other risks are the navigators focus on the system (rather then the person) and can create dependency rather than enable choice and control).

Lack of necessary data infrastructure	• There is limited to no contract, provider and outcome data infrastructure • There are no existing plans to address known data infrastructure issues, and once developed, these will likely take several years to design and embed.
Low evidence base	• Low evidence base of what works generally, or by specific sub-groups
Assumption of same starting point	• Unless challenges, a default assumption that there is a level playing field, which perpetuates bias in what is valued, needed and funded, and who's voice influences decision-making most.
Low trust	• Lack of trust in the health system, its services and processes, among whānau, communities and providers
Structural risks	• Localities matter when commissioning.; the Māori Health Authority has a national and regional presence, but not a local one. The MHA will have to rely on the Iwi Māori Partnership Boards for local context, whānau voice and priorities. • IMBPs have no statutory powers to influence HNZ locality plans although they have a statutory function as a key partner in agreeing plans.
Capability risks	• The IMPBs have differing levels of capacity, capability and maturity, and it is likely to take several years to reach the level of capability and maturity needed for effective representation and influence across the range of health interventions (public health, primary and community, hospital and specialist services)
Ministerial and public expectations	• Ministerial and public expectations of results ahead of full implementation, the time needed for outcomes to change, and the data infrastructure and skills needed to capture outcomes and make meaningful comparisons (over time, to matched groups), challenges separating out contribution from attribution in broader and/or shared outcomes.

Mitigations

As part of developing and implementing the commissioning framework, it would be useful to actively monitor, assess and address potential barriers, as well as identifying any emerging barriers. Below are some ideas on how key barriers and risks can be mitigated, reduced or removed.

- A framework that inspires and guides new ways of thinking, working, delivering, assessing and improving
- Funding and work programme to:
  - build awareness, understanding and commitment to change
  - build a 'road-map' that sets out the path to a new, improved and mature system, with attention paid to the main infrastructure and enabler gaps (contract, provider and outcomes data, evidence on what works)
  - build data infrastructure
  - build workforce capacity and capability
- Use of 'theories of change' and processes to track fidelity to these, to support outcome reporting ahead of implementation, delivery (intensity, duration, frequency), elapsed time for change to occur, and outcome data and analysis options (based on robustness of data).
- Clear communications to manage expectations; case studies to describe change.

Technical guides and supporting comms

- Produce technical guides that ensure legal requirements, procurement principles and good practice guide commissioning, as well as 'comms-friendly' versions to communicate purpose, process and products to stakeholders
- Develop an overview guide (for the H&DS) which sets out:
  - How commissioning needs to change for these service types
  - Roles of new entities in supporting these changes to commissioning

- For each stage of the commissioning cycle[5]:
  - Key shifts
  - What is needed/ how this is done – by key agent (whānau, providers, Iwi Māori Partnership Boards, funders, wider health system and social sector, population ministries, Treasury and MBIE)
  - Key enablers (data, resources, tools, guides, evidence, governance, strategic relationships and priorities, understanding of local communities and contexts, relationships of trust, good processes for procurement and contract management, training, workforce) and pathways for these to mature
  - Accountability and performance measures by key agent; long term and short term
  - Processes for identifying and addressing barriers and constraints across the commissioning eco-system
  - Identifying and prioritising investments needed to improve the commissioning ecosystem
  - Identifying where other levers (eg policy, regulation, public health interventions) could support commissioning in delivering outcomes that matter to whānau and communities, and public value.

Hospital and specialist services

For Hospital and specialist services, provide specific guidance on:

- Workforce pipeline and skills (cultural safety, cross-sector collaboration) as well as technical skills
- Capital investments which meet projected demographics and demand
- Skills and training needed for IMPBs to operate effectively influencing these services and investments
- Identify and address system conditions that act as barriers to access (eg default to centre-based services, opening hours that suit clinicians, appointment times that prevent holistic assessments, understand barriers to treatment (caregiving, economic) and work with social sector agencies to address these)
- Assess inequity in outcomes, and provide insights that will help build a case for change- even if this is led by other parts of the system, or the social sector (eg impact of insecure, poor quality housing)
- Revisit reasons for excluding dental care in the H&DSR and identify options to address the serious and far-reaching inequities caused by barriers to access to specialist dental services
- Build in public health approaches and other levers (policy, regulation) to make greater in-roads to enduring/ intractable problems eg cancers, long term conditions

[5] i) Purpose and understanding, ii) Designing and planning, iii) Sourcing and investing, iv) Delivery, monitoring, evaluation and continuous improvement.

Primary and community care

For primary and community care provide specific guidance on:

- Co-ordinated and proactive provider capacity and capability building with the social sector
- Active identification and removal of barriers to entry, and sustainability, for providers
- Identifying system conditions that may act as a barrier to accessing primary care, eg partial fees for services as the largest proportion of income for GP/PHO businesses, and using policy levers to change these system conditions
- Revisit reasons for excluding dental care in the H&DSR and identify options to address the serious and far-reaching inequities caused by poor oral hygiene, and barriers to prevention and early treatment
- Co-ordinated and proactive provider market shaping for providers, particularly Māori and Pacific provider market with the wider social sector.
- Skills and training needed for IMPBs to operate effectively influencing these services and investments
- Build in public health approaches and other levers (policy, regulation) to make greater in-roads to enduring/ intractable problems which could be improved by stronger preventative investments
- Provide insights that improve public health and primary care investments.

Public Health services

For public health services specific guidance on:

- the PHA role developing technical services specifications for population and public health for use in commissioning, and an important area for collaboration between the PHA and the NPHS
- the PHA role in improving oral hygiene and health, as part of ensuring the serious and far-reaching inequities stemming from systemic barriers to accessing preventative dental care are addressed.

What we need to do differently: key shifts

To help people understand what is being done differently, it would be useful if the commissioning framework helped set out the shifts needed at each stage of the commissioning cycle, and link these to the key participants.

An overview of the key shifts is shown in the table below, against the key participants in the commissioning ecosystem Appendix 4 show the key shifts by the main commissioning cycle stages, as well as the the short and longer-term accountabilities to ensure the shifts are made and have led to improved outcomes.

	Conventional commissioning	Whānau and Māori-led commissioning
Whānau	• Barriers to accessing health care are created as whānau needs, capability and context are not understood • Propagates a power imbalance as professionals decide what's best for service users and whānau	• 'What matters to whānau' shapes system and service design • Whānau are seen as having strengths, social capital and capability • Whanāu are enabled to exercise choice and decision making for their own health and wellbeing.
Providers	• Services are only enabled to treat symptoms, conditions and people in silos. • Funding is easier to secure for services with a western bio-medical approach	• Services are integrated and multi-disciplinary teams take a holistic approach, 'working with' people and their whānau. • Root causes can be addressed with a focus on determinants of wellbeing, and strengths built.

	• Innovation is restricted as funding comes with highly specified deliverables • Funding levels are often below cost of delivery • Multiple contracts are needed from to stay afloat.	• Funding can be secured for the full range of rongoā Māori healing practices • Innovation is enabled as contracts support development of new approaches using co-design. • Funding levels cover the cost of delivery and sustainable. • Funding is pooled/integrated and/or reporting compliance costs reduced.
Funders	• Contracts and performance measures focus on outputs and embed a disease and deficit approach, as these are easier to track • The process to apply for funding is onerous and reporting is rigid in approach • Contracting practices have narrowed what is really possible within existing rules. • Focus is on unit cost and short-term efficiencies	• Focus is on outcomes, with evidence-based theories of change on what is needed, including funding, time and other resources. • Contracts and performance measures track fidelity to evidence of what works, and contributions to the 'journey' and broader, more sustainable outcomes are valued. • Funding applications are streamlined and short term (time limited) one-off investments to support innovation can be approved using a 'lighter' business case, aligned to the level of risks identified. • Reporting is developed with providers, to ensure measures contribute to continuous improvement. • Innovation within existing rules is encouraged. • Thinks about costs across the system, with a focus on prevention and long-term public value.
System	• Separated roles: service users seen as passive, service expectations rest with the provider and funding decisions made by the funder.	• Collective or shared accountability through joint decisioning-making, including funding allocations (through Iwi Māori Partnership Boards.)
System conditions	• Western bio-medical models and clinical perspectives are privileged • Professionals are experts, and 'do to' service users and whānau • Services break people into problems to be fixed • Structural and systemic racism influences investment decisions • Productive efficiency valued (unit cost) • Treasury and the Ministry track funding and investment by service lines (eg, tobacco control, alcohol and other drugs, nutrition and physical activity, etc) which limits thinking, and opportunity for more strategic investment • Inward-looking focus on health sector	• Mātauranga Māori and rongoā are valued. • Whānau are experts in what works for them, and their insights shape system and service design • Professionals 'walk alongside' whānau, and enable choice and control • Structural and systemic racism are called out and addressed • Allocative efficiency valued (whole of system cost, including costs borne outside of the health sector) • The Ministry (supported by Treasury) re-shape Purchase Unit IDs to track funding by core functions to support more strategic investment (see Public Health approach). • Connects to wider social and economic sectors
Enablers	• There is no easily accessible data on providers or on the contracts they receive, within health, let alone other sectors. • Low capacity and capability in commissioning skills; commissioning seen as contracting third party providers.	• Provider, contract and reporting data infrastructure is developed and actively used. • Build people and teams so the broad range of skills needed for effective commissioning are available, both nationally and locally: engagement, analysis, prioritisation, contracting, relationship management, monitoring, continuous improvement

Changes in how we trust, think, act, fund, deliver, assess

The commissioning framework could help articulate and communicate the changes in the way we trust, think, act, fund, deliver and assess that need to be manifested to bring about transformation.

Trust	• Commissioners need to invest in relationships with providers and potential providers • Time is needed to allow whānaungatanga and build relationships of trust • At the start, trust needs to be built on a clear foundation of the purpose of the relationships, any non-negotiables and external requirements (eg, legislation, Budget processes and requirements, Ministerial expectations) • Other pre-conditions also need to be clearly communicated. • Trust is maintained with open and timely communication, flexibility when responding to emerging issues or opportunities, and having each other's back when things don't go as well as planned.
Think	• **Te Tiriti principles** reflect what works when commissioning for better and enduring outcomes • Te Ao Māori contains kawa (knowledge) and tikanga (ways of working) that will improve outcomes • Whānau have strengths and capabilities • **'What matters to whānau'** shapes system and service design, delivery and improvement • We are accountable to Māori
Act	• We need to work together, and trust needs to be rebuilt between whānau, communities, providers and funders • We will be learning partners, and find out what we need to do better • We will challenge the status quo and do new things - this will feel uncomfortable for many (and mainstream) and a relief to others as we finally do what Māori have been wanting for decades • We'll work to manage risks, and our leadership teams will have our backs
Fund	• Funding shifts to focus on: - 'what matters to whānau'; the change isn't real until this happens - prevention (active protection) over time; the change is real until this happens • We commission for a longer term and stop doing lots of small contracts which don't cover true costs of delivery and take providers away from their real work to meet reporting requirements that don't add value
Deliver	• We enable services to become more holistic, collaborative and integrated • We enable providers to practice **mātauranga Māori and rongoā Māori** • Services deliver what matters to whānau, and are enabled to stop doing things that aren't
Assess	• Outcomes measure what is **meaningful to whānau** • Providers shape monitoring and accountability requirements with funders, so useful information is reported and helps support continuous improvement • **Te Ao Māori outcomes framework and kaupapa Māori research** builds understanding of what works and why • Theories of change and measures of public value support bids for sustainable (not just prototype) funding, and demonstrate better outcomes from commissioning for pae ora
Improve	• The evidence of '**what works for whānau**' reshapes services and future investments • We can re-shape or stop services that no longer deliver what matters to whānau, and use clear processes with good lead-in times so providers are not put at risk • Over time funding moves upstream, to prevention • We identify where other levers are needed, eg regulation (eg to address food environments)

Commented [JO1]: For example, if an aim is to demonstrate the impact and/or social cost benefit, initiatives need to be delivered with enough intensity and/or duration to enough people to allow meaningful comparison (either the same people before and after, or with matched comparison groups or propensity analysis). Time is also needed for the numbers to build the numbers needed, and allow outcomes to be achieved.

Commented [JO2]:
Good commissioning
- supports tino rangatiratanga by enabling choice, control and autonomy of decision-making for whānau
- improves options for whānau by having a range of accessible, culturally safe and effective services and supports, facilitating choice
- builds partnerships through investing in effective and accessible kaupapa Māori service providers and supporting resilience in provider markets
- creates active protection by building the capability of people, whānau, providers and communities, and influencing the conditions which contribute to health and wellbeing
- …. and these combine to improve equity of health and wellbeing outcomes, by responding to people in the context of their whole selves, and their whānau and community contexts.

Build	• We build teams with the technical skills and whānau and community engagement skills to commission well, including understanding of **Te Ao Māori, tikanga and te reo** • We take time to build and maintain relationships, and budgets to allow more kanohi ki te kanohi meeting • We develop tools and resources with providers that help them meet accountability and reporting requirements with minimal effort • We understand gaps in the provider market, and actively build existing kaupapa Māori providers' capacity and capability, as well as support new providers as they set up.

Commented [JO3]: Te Tiriti, equity and needs analysis, co-design, service design, prioritisation, procurement and contracting, risk management, monitoring and evaluation, continuous improvement, decommissioning and change management.

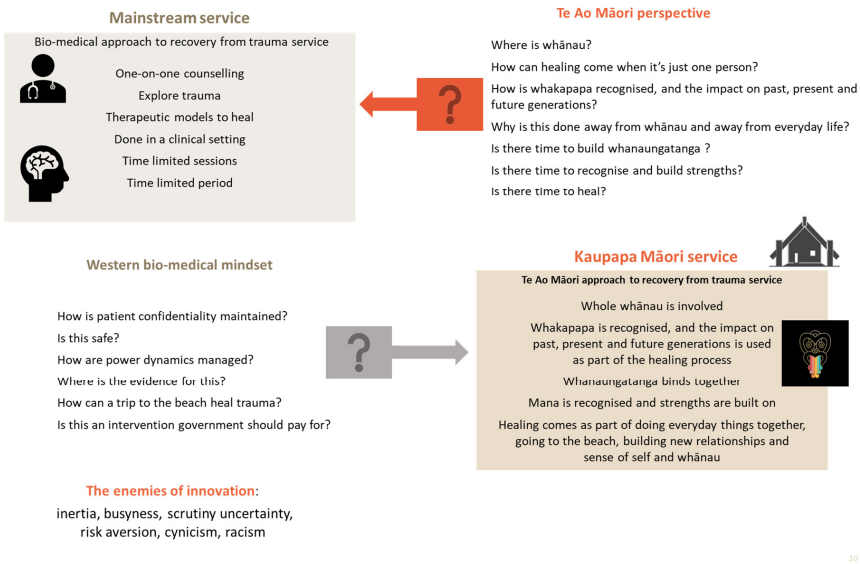
The enemies of innovation: inertia, busyness, scrutiny, uncertainty, risk aversion, cynicism, racism

- Inertia: the biggest enemy of innovation is inertia. It is much harder to try new things, and encounter opposition, uncertainty and potential failure than it is just to keep doing what we have always done.
- Busyness: Innovation takes time, to think differently, explore ideas, set up co-design processes/sessions, find people with different perspectives to join in, then wrangle ideas and work through differences. This is hard in the busyness of service delivery, let alone with a pandemic and sector reform to deal with at the same time
- Scrutiny: there is often pressure to report back on results early on, without sufficient time for implementation, let along improvements in outcomes. The level of scrutiny applied to innovation, and to Māori providers is often also much higher and more public
- Uncertainty: not knowing if the innovation will work can make it hard to get funding or a mandate to go ahead, and the uncertainty of success can make it hard to stay on course when implementation bumps inevitably occur.
- Risk aversion: It is appropriate to have a level of risk aversion when using public funding; how it is invested matters. But the risk of not taking action when current investments consistently fail groups within our community can galvanise action.
- Cynicism: Innovation requires optimism and curiosity.
- Racism: Within the large apparatus of government and the many staff employed, there will be people who are racist. There will also be people who are unaware of the inequitable impacts of policy or service design on some groups, or the impacts of privileging some types of activity or evidence over others. And beyond people, there are systems, structures and processes which create racist outcomes.

Commented [JO4]: Ao Mai Te Rā is a multi-stranded work programme to remove racism in the health and disability system

Figure 3 sets out approaches to trauma services that are part of the mainstream, and an innovative approach being trialled by a Māori provider. (This provider is not funded by the Ministry of Health, as they found our funding application processes too hard).

Figure 3: Different world views on trauma services (based on a service outside of health funding)



Developing Models of Care: example of a product of commissioning process

Models of cares set out best practice and services or response for a person or group as they progress through a condition, injury or episode of care.)A model of care is not limited to health and disability services; it may include social and cultural services that support the delivery or outcomes of health care. [6])

The commissioning framework could show how models of care can be developed, applying the principles and approaches recommended.

Designing for success

The model of care will drive how the service is designed and delivered, so it must be an evidence-informed, agreed model that will meet the needs of the people, whānau and community identified.

Other factors which contribute to designing for success are shown below.

	To be successful, models of care need to:
Whānau	• ensure service users and whānau shape the purpose • takes a holistic approach to pae ora and includes services outside the health sector • ensure services are accessible, affordable, high quality, culturally safe and effective
Providers	• have service delivery that is underpinned by a robust framework that reflects clinical and non-clinical aspects of care • focus on resilience and recovery • use data to inform practice.
Funders	• equitable funding models, which also focus on shifting investment up-stream to prevention over time

[6] The section on Models of Care is adapted from the NZ Commissioning Framework for Mental Health and Addiction https://www.health.govt.nz/publication/commissioning-framework-mental-health-and-addiction-new-zealand-guide

	• prioritise services/responses that reflect evidence and promote the development of best practice (defined as dynamic, evidence-informed, innovative and open to change) • prioritise services/responses that are culturally competent as well as clinically competent and that reflect whānau ora
System	• use surveillance of health and diseases to develop funding models, service planning and development, alongside broader demographics • be able to relate to other models of care across sectors and at different levels of operation (national, regional, local). • span a range of services, including primary, secondary and tertiary services, those provided by NGOs and those provided in the community • be developed in partnership, with a multidisciplinary and inclusive approach, as all those who will be involved in service delivery need to understand both the model and the principles that underpin it • have clear roles and responsibilities and philosophical differences explored, as these will have an impact on service delivery if not resolved. Depending on the type of response being developed, there may be an overarching model of care reflecting a whole-of-system approach, or it may be more appropriate for the model to be developed to reflect individual service-level expectations.

Demonstrating success

Models of care are important at all phases of the commissioning cycle: they influence opportunities and planning, they need to be monitored and evaluated to check that they are working as expected, and they must be revised and adapted as appropriate to achieve expected outcomes.

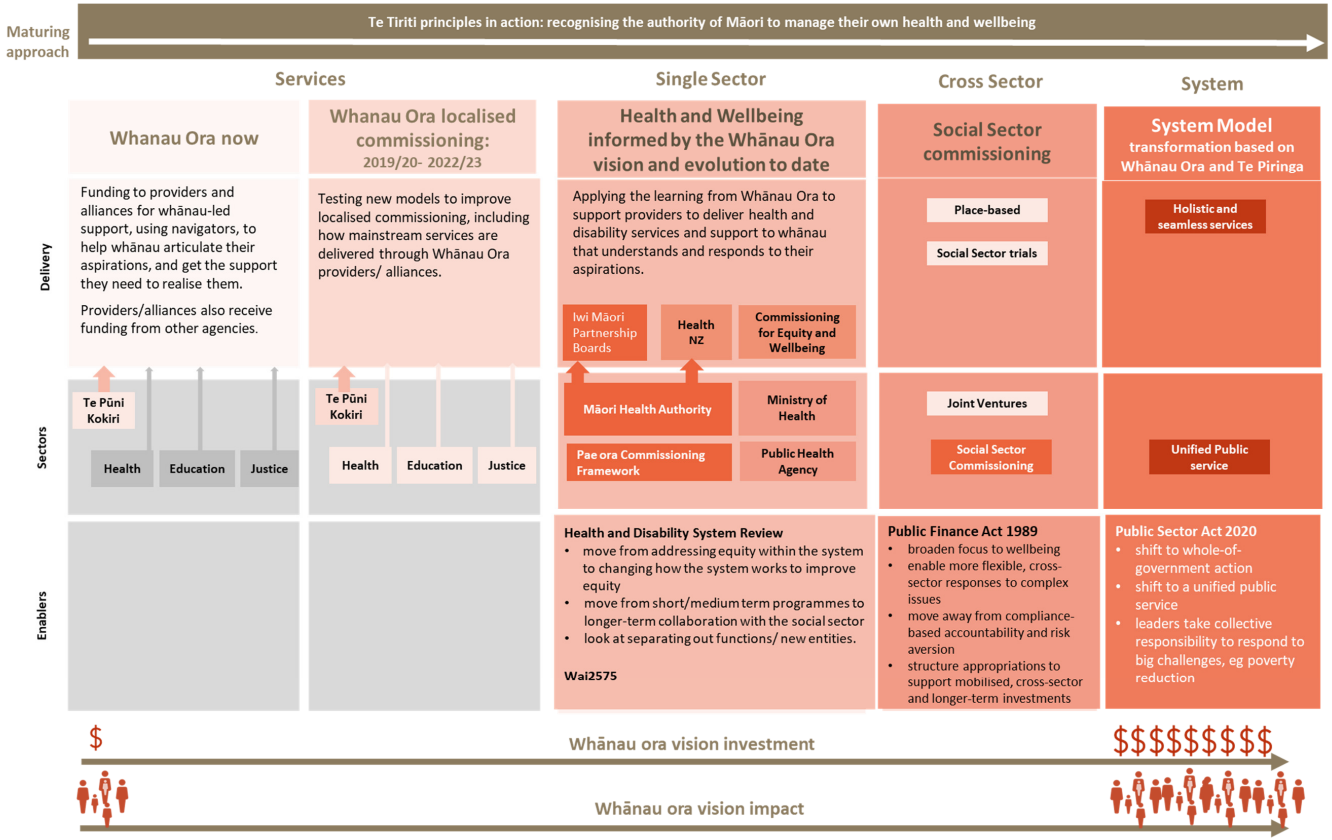
Regular monitoring and evaluation of new services also help to identify whether those services are continually developing as expected.

Other factors which contribute to demonstrating success are shown below.

	To demonstrate success, models of care need to:
Whānau	• assess whether services are delivering outcomes for whānau • describe how people with lived experience and whānau were part of the model's design, and what changed because of their contributions • understand changes in context that may have impacted on outcomes
Providers	• Have clear accountability and reporting requirements • tools to support allow data collection throughout the delivery period
Funders	• the information (quantitative and qualitative) that needs to be collected throughout the lifetime of the model • have performance measures which are developed with providers and drive continuous improvement and provide a clear line of sight to track progress in meeting Government and Ministry strategic goals and outcomes • ensure services are run well, monitored, avoid duplication, and are safe, timely and efficient.
System	• the philosophy, evidence and/or assumptions behind the model • the theory of change/ intervention logic used to design the model and the measures • the goals and expected outcomes • outcome measures which can demonstrate improvements for service users, whānau and populations • the implementation plan for the model of care.

Appendix 1: Expanding the whānau ora vision

The enabling environment has changed, which means the whānau ora vision can now more easily expand into the health and disability system, and across the broader social sector.



Appendix 2. Commissioning framework can support planning and investment across the life-course, and types of investments

Appendix 3. Maturity model for commissioning, by key participants in the commissioning ecosystem

	Current state	1-2 years	3-5 years	10 years
WHĀNAU 	Get what the system thinks they want Are seen as passive recipients in their health and wellbeing journey Seen as 'problems to be solved'	Can exercise choice over what service and support they use Enabled to be active participants in their health and wellbeing journey Services work with the whole whānau	The right support can be accessed easily, and early on: - in life, and - in the life of a problem	Experience seamless access to whānau-centred services across the life course Strong health literacy 'Core economy' of people, whānau, community is strengthened; social connections rebuilt and flourish
PROVIDERS 	High compliance costs across piecemeal contracts Funding approaches make it hard to attract, train and retain staff	Deeply understand the community and context Whanaungatanga and building strong, trusted relationships is valued Co-produce whānau-centred, culturally safe services	Continuous improvement includes clinical, cultural and community insights Innovation embedded Can attract and retain skilled workers	Enabled to work collaboratively with other services Leadership supports innovation and adaptive management; services and staff can flex to meet new challenges and opportunities
FUNDERS 	Low trust Outputs focused contracts Deficit and disease focused Siloed approach Application process favours larger providers with good bid writers	Contextualised understanding Enable high trust relationships and encourage innovation Process supports diverse provider pool Contracts support outcomes Monitoring builds insights	Take a capability building approach; for providers, and for whānau and community Collaborate across the social sector, and collective accountability Funding and other support to ember innovation	Devolved funding and decision-making Broader provider pool get funding Whānau outcomes and innovation are incentivised Health, wellbeing and equity outcomes improve
SYSTEM 	Lack of clarity of roles and purpose, leading to gaps, overlaps and wastage Problems need to escalate to reach thresholds for action	Investment focuses on prevention and broader determents of health and wellbeing (causes, not symptoms) Workforce pipeline to meet changing demand, collaborative working and outcomes-focus		Investments are guided by evidence, te Tiriti principles, whānau voice, robust data and forecasts. "Wastage', and human and financial costs are reduced as system agents work well together Sustainable investment and effective workforce pipeline

Appendix 4: Key shifts and accountability across the commissioning cycle – primary and community care

The Pae Ora and Commissioning for Equity and Wellbeing Frameworks set out what needs to change at each stage of the commissioning cycle to move to community, whānau and Māori-led commissioning.

The four broad commissioning stages are determining:

1. Purpose and understanding
2. Designing and planning
3. Sourcing and investing
4. Delivering, monitoring and evaluating.

Expectations on how the health entities can support commissioning for pae ora is noted, along with the role locality networks, **Iwi Māori Partnership Boards**, and the broader Social Sector Commissioning work.

4.1 Purpose and understanding

Aim: To understand and define the need or opportunity, the outcomes wanted, what's already known to work, and readiness for action.

Key steps

- Determining purpose: identifying the need or opportunity, who is impacted and desired outcomes
- Understanding demand: exploring the size and nature of the problem or opportunity, now and in the future
- What's known to work: from whānau and provider insights, Iwi Māori Provider Boards, locality networks, key stakeholders and research
- Readiness for action: understanding provider capacity and capability to respond.

To make a real improvement to health and wellbeing outcomes, service users and whānau need to shape system and service purpose. Effective system transformations start by understanding the need and purpose – and outcomes are better when service purpose reflects 'what matters' to service users and whānau.[7]

Commented [JO5]: The 'what matters' to whānau ensures the focus stays on outcomes eg living in a safe secure home. Because government has most control over what it delivers, it is easy for agencies to focus on outputs, eg X number of people placed into state housing. 'What matters to whānau' changes the focus to quality measures of suitability of the house for the whānau, location for work, schools and connection to other whānau, safety, tenure etc.

Key shifts at the purpose and understanding stage

	From conventional commissioning	To whānau and Māori-led
Whānau	Assumptions about what matters and what works for whānau People, whānau and community are seen through a deficit and disease lens, needing to be 'fixed'	Service users, whanau and community help shape the purpose so systems and services focus on '**what matters**' and '**what works**' for them A strengths-based approach is taken Support and services 'work with' people and whānau
Providers	Providers have little to no input Low buy-in; 'just more change'.	Providers are included in shaping service design, and their knowledge and experience is valued and used.
Funders	Understanding need is predominately 'desk job' based on quantitative data	Lived experienced provides insight into what is impacting on people and whānau's health and wellbeing, what is working well and what needs to improve in current service provision.
System	Low inquiry into provider capacity and capability	Capacity and capability of providers to deliver is a key part of understanding what's needed.

Commented [JO6]: If change happens to you, rather than with you, it can be disempowering and lead to cynicism. The 'co' is key: co-discovery, co-design, co-creation, co-production, to get and keep momentum over time See https://oecd-opsi.org/what-makes-for-a-good-innovation-strategy

[7] https://locality.org.uk/about/key-publications/saving-money-by-doing-the-right-thing/

From the evidence, what would enable successful commissioning at the purpose & understanding stage?

	Shorter-term	Longer-term
Ministry of Health	Prepare the sector and Ministers for a change in the direction and types of services that will be commissioned (including allocative efficiencies) Exercise leadership and courage as services change to deliver what matters to whānau Prioritise commissioning activities that will achieve improved Māori health and equity. Support effective allocation of resources and identify and address barriers Develop equitable and sustainable funding approaches, which incentivise removing 'waste', building value, innovation and quality improvement	Monitor the extent to which service and system purpose has been shaped by whānau for all commissioning agents in the health and disability system Enable joint work programmes across Māori Health Authority, Health NZ and the Public Health Agency, and across sectors. Support the workforce pipeline to ensure there is capacity, capability and flexibilty
Public Health Agency	Provide population-level data and insights into health inequities, root causes and factors that drive persistent disadvantage Share public health methods that could support system and service design to deliver what matters to whānau	Develop and implement other levers to complement commissioning; for example regulatory levers to shape food environments.
HQSC	Provide insights from the consumer networks	Enable a broader network of service user engagement
Health NZ	HNZ to invest in determining system and service purpose with service users, community and whānau, build a robust surveillance system, review current investments for value, accessibility and effectiveness, health needs analysis, epidemiology, co-production methods and human-centred design, research, evaluation and continuous improvement, alongside collaboration with the IMPBs and the Māori Health Authority to understand what matters to whānau and support their priorities for action.	Build a common data and digital platform to track data and outcomes Use strategic and longer-term advice from IMPBs and the Māori Health Authority on areas for investment.
~~Māori~~ Health Authority	Develop strong, high trust relationships with IMPBs Act on guidance from IMPBs on what matters to whānau at the locality and regional levels	Use advice from IMPBs and locality planners to develop areas for strategic investment and system-level change
Iwi Māori Partnership Boards	Deep connection with, and understanding of, whānau, communities and contexts Resources, design thinking and engagement processes to: capture 'what matters to whānau' contextualise what matters to whānau identify common themes across rohe and motu influence system and service purpose, so it reflects 'what matters to whānau' identify capability needs to support whānau engage in shaping system and service purpose identify system conditions that make it hard to determine what matters to whānau	Build the kete to capture what matters to whanau, including identifying emerging and unmet needs. Consolidate common themes, and make recommendations on changes needed at a system level Build succession-planning so their rangatahi start to gain experience, insight and leadership

Social sector	Collaboration across sectors and implementing the Social Sector Commissioning work programme	Coordination of engagement with Māori, to reduce consultation fatigue Collective accountability of Māori and equity outcomes.
Te Puni Kōkiri	Share lessons learnt from managing and evolving Whānau Ora from a service, to a provider, to a commissioning agency	Provide guidance on how to shape 'what matters to whānau' in a way that reflects Te Ao Māori framing
Min. Pacific People	Collaborate to support the enacting and embedding of the Te Piringa research recommendations on improving health for pacific people, Ola Manuia and other pacific people-focused strategies	Provide guidance on how to shape 'what matters to pacific people and communities'
ACC	Collaborate to understand risk factors for avoidable harm and injury, adequacy of current responses and priorities for the future Review existing services for potential bias and/or inequity (in communities, contexts, access and outcomes) Identify opportunities for joint research to build evidence and insights of accident and harm protection across the broader health and social system	Develop actuarial models to support innovation in the health system
Treasury	Clear articulation of the purpose of agency funding Macro-level influences on demand Emerging issues Support tracking of investment by public health core functions	Review of system and service purpose identified from commissioning work in the health and social sectors, to build a broader view of what matters to whānau

4.2 Designing and planning

Aim: To design innovative responses to improve outcomes, using prioritisation criteria and assessment of public value, supported by a plan of action.

Key steps

- **Designing**: what will improve outcomes?
- **Deciding priorities**: and what success will look like
- **Planning**: sequence of actions and approvals needed to turn the idea into reality.

Key shifts at the designing and planning stage

	From conventional commissioning	To whānau and Māori-led
Whānau	Services are not designed around what matters to whānau	Service users and whānau shape system and service purpose so it delivers 'what matters to them'
Providers	Providers' expertise in delivery, and understanding of local contexts and communities is not drawn on	Providers are engaged in the design of new approaches Providers shape meaningful performance measures that explain variance in outcomes and support continuous improvement
Funders	Top-down approach stops innovation Funding follows historical patterns Narrow range of options considered Efficiency and unit cost to deliver services are used as measures of value.	Enable design thinking with diverse inputs, and ensure service users, potential service users and whānau shape the system and service purpose, and the outcomes that matter to them Enable thinking around 'what's possible' Use theories of change and staged approaches to manage uncertainty Costs across the system and public value replaces unit costs analysis.
System	Provider failure, or service users not trying hard enough are seen as the main reasons why outcomes have not improved as hoped.	System conditions are recognised as impacting on outcomes, including what evidence is valued, how innovation is enabled, and the impact of systemic and institutional racism on service design.

From the evidence, what will enable successful commissioning at the designing and planning stage?

	Shorter-term	Longer-term
Ministry of Health	Monitor the designing and planning processes used and products developed by health and disability entities to ensure whānau voice shaped system and service design	Support investment in workforce development, training and funding to enable innovation alongside maintaining quality and safety Workforce pipeline to ensure collaborative, cross-sector and multi-disciplinary skills are available, as well as the technical and engagement skills needed to commission well. Scholarships to attract Māori into commissioning, co-design and evaluation roles
Public Health Agency	Share public health systems thinking, research and tools that could support system and service design to deliver what matters to whānau	Joint planning and investment to combine public health interventions alongside service design to improve outcomes for Māori and build active protection

Commented [JO7]: While service users and whānau are now more commonly involved as the service design stage, this framework aims for co-production throughout all stages; starting at purpose and continuing right through to continuous improvement, evaluation and shaping priorities for future investment stages.

HQSC	Share guidance on how to embed quality and safety into service design	Support capacity and capability of kaupapa Māori service providers in delivering quality and safe services, while retaining Te Ao Māori approaches
Health NZ	Collaborate with IMPBs and the Maori Health Authority to identify gaps in services across the levels of intervention (primary, community, secondary, tertiary) and between service provider type (eg private GP and PHOs and public health services and NGOs Development of • Health NZ Plan • workforce strategies • service strategies Review of the National Service Framework Library Locality planning	Develop integrated care models to reduce gaps and improve transitions between levels of care and provider types (private, public, kaupapa Māori, NGO) Development of: • Health NZ Plan • workforce strategies • service strategies • national service specs framework Locality planning
Māori Health Authority	Enable innovation at the locality level, through funding, tools, resources Provide guidance, tools and support to ensure innovations can meet government accountability requirements Build capability in design-thinking using Te Ao Māori framing	Identify capacity and capability constraints in kaupapa Māori providers, and the provider market as a whole Develop and test methods for assessing public value that align with Te Ao Maori framing (building on social cost benefit analysis and social return on investment methods, which include wellbeing measures) with Te Puni Kokiri and Treasury
Iwi Māori Partnership Boards	Enable local engagement and design of services Develop 'Theories of Change' which reflect Te Ao Māori framing of issues and how actions will influence outcomes	Develop and share Te Ao Māori framed Theories of Change, models of care and service designs that reflect what matter to whānau, noting pre-conditions for success. Involve people with different lived experiences and perspectives so their hopes for the future shape the present, and build in succession planning.
Social sector	Identify areas to prototype more integrated approaches to health and social services	Develop integrated models of care for health and social services. Use technology and innovations to solve 'wicked problems'
Te Puni Kōkiri	Monitor funding allocated to Kaupapa Māori providers Develop guidance on what constitutes a Kaupapa Māori provider or service	Develop and test methods for assessing public value that align with Te Ao Maori framing, with Treasury MHA Identify capacity and capacity needs across kaupapa Māori providers Potential accreditation of services according to their capacity, capability to deliver kaupapa Māori services…?
Min. Pacific People	Monitor funding allocated to Pacific providers Develop guidance on what constitutes a Kaupapa Māori provider or service	Develop and test methods for assessing public value that align with Te Ao Maori framing, with Treasury MHA Identify capacity and capacity needs across kaupapa Māori providers Potential accreditation of services according to their capacity, capability to deliver kaupapa Māori services…?
ACC	Develop targeted innovations, in collaboration with different parts of the health system (public health, primary and community, hospital and specialist)	Develop joint work programmes and investment strategies

Treasury	Provide guidance on measuring wellbeing and collective impact.	Review requirements in Budget Bid templates to allow innovative and integrated services to meet evidence standards required to access sustainable (not just prototype) funding Develop and test methods for assessing public value that align with Te Ao Maori framing, with TPK and MHA

4.3 Sourcing and investing

Aim: To find the right provider to deliver the service or support, using contract requirements to ensure that what is delivered '**works for whānau'** and is a good use of public funds.

Key steps

- **Sourcing**: deciding the right sourcing approach to deliver the service purpose, then undertaking appropriate sourcing for delivery of services
- **Investing**: developing the contract with conditions to enable and incentivise the desired outcomes

Provider markets

Commissioning requires a 'market' of service providers able and willing to bid for contracts and provide services within a commissioning framework.

How are provider markets shaped?

The mix, breadth and depth of provider markets are shaped by an interplay of:

Market drivers	market drivers which can attract providers to set up, in response to consumer demand, government policy and new technologies certainty of future demand, based on historic delivery patterns and projected changes in demographics, context, competition and anticipated need
Capacity and capability	the capacity and capability of existing providers to meet current and future demand, including provision of new services or services in new locations changes in the availability of better alternative providers, meaning some providers cease to attract funding or service users.
Barriers to entry	barriers for new providers, including set up costs, meeting service standards, regulatory requirements and uncertainty of demand

Market stewardship

Government sometimes intervenes to ensure there are resilient service systems with well-functioning providers and provider markets, which are essential for effective commissioning. Government can:

Support providers	sustain existing providers (funding levels and contract periods enable providers to recruit, train and retain skilled staff) encourage new providers (to improve diversity, innovation and options) by removing barriers to entry, supporting with set up costs and sustainability (eg guaranteed contract volumes and longer contract periods)
Incentivise	incentivise collaboration between providers (and removing competitive contracting) incentivise services to match demand (locations, populations, service types, modes of delivery).
Manage risk	manage risk by transitioning services in or out of government without due consideration for market depth, user maturity, and service continuity.

A risk to guard against is replacing local services, which provide good care but lack capacity or expertise to applying for contracts with 'outside' services who have the capacity and expertise but lack the local relationships.

Key shifts at the sourcing and investing stage

	From conventional commissioning	To whānau and Māori-led
Whānau	Fewer options of kaupapa Māori services	Increased options for kaupapa Māori services
Providers	Barriers to entry for new kaupapa Māori service providers Commissioning may negatively disrupt local provider systems if processes exclude good providers from tendering/applying Contracts do not cover full cost of service delivery Contracts are highly specified Performance measures do not provide useful insights; just track outputs High compliance costs from multiple small contracts, with different reporting requirements Low capacity for innovation Low trust on support, or future contracts, if new ideas don't work	Support for new kaupapa Māori providers to establish (grant funding, capacity building, mentoring) Streamlined reporting Co-designed reporting, so providers can 'tell their story, and the information is useful to them and funders Use of existing data Requirements to share data Reduced manual input
Funders	Low use of theories of change at the design stage makes it harder to translate key requirements into the contract Limited research on what contractual levers support: provider performance better outcomes for whānau Data does not provide insights on variations Data does not support continuous improvement Lack of understanding of the end-to-end commissioning process Limited workforce with the range of technical and engagement skills to commission well	Monitoring reports are actively reviewed and used to support continuous improvement; for service design, delivery and commissioning processes. Workforce capability, training Support a learning culture, and front-foot criticism when new ideas fail
System	No active market shaping for kaupapa Māori providers Limited pool of kaupapa Māori evaluators	Active market shaping of kaupapa Māori providers, in partnership with the social sector Support a learning culture with leadership that can respond to criticism when new ideas fail

From the evidence, what will enable successful commissioning at the sourcing and investing stage?

	Shorter-term	Longer-term
Ministry of Health	Monitor contracts with kaupapa Māori providers (purpose, provider, location, amount, duration) Manage risks if decommissioning kaupapa Māori contracts and continuity planning	Monitor outcomes from whānau-shaped, Māori-led commissioning Accessible and accurate provider performance data, including service user outcomes and satisfaction Monitor the devolution of decision-making power and funding to Iwi Māori Provider Boards and locality networks
Public Health Agency	Identification of issues that require public health levers to influence	Coordinated investments and assessments to test the benefits of combining public health interventions alongside service innovation
HQSC	Guidance on quality and safety standards	Review of quality and safety of kaupapa Māori service providers and areas for support
Health NZ	Co-commissioning with the Māori Health Authority Review of investments by provider type, service type and location Reviewing and addressing barriers to accessing funding for kaupapa Māori providers Develop an investment strategy to increase funding to prevention over time	With the Māori Health Authority develop an investment strategy to build the capacity and capability of kaupapa Māori service providers, and the kaupapa Maori provider market overall (with input from MSD/ Social Sector Commissioning) Increase contracts and funding for kaupapa Māori providers Increasingly move funding to prevention Support IMPB's to guide locality commissioning
Māori Health Authority	Examples of types of innovation already possible within existing sourcing rules and procurement principles Co-commissioning with Health NZ Review of Health NZ's investment into kaupapa Māori services and service providers Tools to reduce compliance costs for providers	Monitor the capacity, capability, depth and breadth of the kaupapa Māori provider market, recommend an investment strategy Monitor funding and funding conditions received by kaupapa Māori providers by funding source; do the patterns demonstrate increasing trust? Enable IMPB's to guide locality commissioning
Iwi Māori Partnership Boards	Feedback on barriers to access funding experienced by kaupapa Māori providers Capacity and capability pressures for these providers	Insights on system enablers and constraints to access prototype and sustainable funding for kaupapa Māori providers Involve rangatahi in prioritisation; it's their future being shaped
Social sector	Sharing insights on sourcing and investing best practice to build diverse provider markets and sustainable kaupapa Māori providers Tools to support contract design and reporting that reduces compliance costs	Accessible and accurate provider performance data, including service user outcomes and satisfaction Lead capability building and market shaping of kaupapa Māori providers, in collaboration with the Ministry of Health, Health HQSC and Iwi Maori Partnership Boards
Te Puni Kōkiri	Review investments across the health and social sectors in kaupapa Māori services	Support whānau-level and Te Ao measures of success, and how these can be developed to support prioritisation decisions (eg improved equity, improved public value)

	Advise on how to protect data sovereignty alongside build and evidence-base of what works	
Min. Pacific People	Review investments across the health and social sectors in Pacific providers and services	Support measures of success that matter to pacific people and reflect their diversity
ACC	Collaborate on supporting diversity and innovation in providers and provide markets involved in prevention, treatment and rehabilitation from avoidable harm and injury	Support good practice in contracting for outcomes and key enablers required at the system level for prevention, treatment and rehabilitation from avoidable harm and injury.
Treasury	Clarity on the requirement to use Better Business Case templates for innovation outside of usual procurement practices Review MBIE sourcing rules and AOG panel from an equity lens; do they create unintended barriers to entry for some providers (focus on services needed in whānau-led commissioning, eg design-thinking, monitoring and evaluation)?	Respond to systemic barriers faced by kaupapa Māori providers to access funding Support Budget Bids to develop emerging kaupapa Māori Providers and build the kaupapa Māori provider market Monitor the shift of funding across the health and social sectors up-stream to prevention

4.4 Delivery, monitoring and evaluation

Aim: To implement the service or intervention, monitor how it delivers against intended operation and budget, and evaluation of outcomes - what worked well and lessons learnt.

Key steps

- **Delivery:** ensuring what is needed to deliver the services are well are in place and services are delivered as intended
- **Monitoring**: tracking delivery against intent; what was delivered, when, to whom, how often, how long and at what cost, reasons for variations, issues, risks and risk management
- **Evaluation**: did the service or intervention generate the desired outcomes, reasons why (or why not), what worked well, and what needs improvement?
- **Improve, or decommission**

Key shifts at the delivery, monitoring and evaluation stage

	From conventional commissioning	To whānau and Māori-led
Whānau	System and services make assumptions about what matters and what works for whānau	What matters to whānau shapes service design and delivery Outcome measures are meaningful to whānau
Providers	Monitoring and reporting requirements are a often a burden, and the data does not add insights[8] Monitoring can be seen as reflecting 'surveillance and suspicion' from the funder, rather than focusing on learning and improvement.[9]	Monitoring uses existing data wherever possible Providers shape performance measures, so data creates insight on what needs to be improved Monitoring is more about learning together, and supporting improvement

[8] Ministry of Social Development. 2020.
[9] Ministry of Social Development. 2020.

		There is trust; when things don't work as hoped, the insights are valued and propel improvements
Funders	Monitoring and evaluation focus on outputs, as these are easier to assess and attribute Services are commissioned with a lack of a clear purpose, or understanding of how the service will lead to outcomes Outcome measures don't measure change from the service (what's expected is more than the service could reasonably influence or measured before change could occur).	Outcomes matter, and whānau views on what worked and why helps shape service improvement A learning culture means qualitative data on why things worked, or didn't, is valued as it helps shape what's needed to improve The mix of influences on outcomes is understood A maturity model helps mark out the steps to a mature system and track progress and inform areas for investment.
System	Monitoring and evaluation don't assess value for money; they focus on cost of delivery only Lack of public value assessment means it is hard to know which service to re-invest in.	Te Ao Māori framing shapes new ways of assessing public value There is increasing sophistication in investment decisions to improve outcomes for Māori, based on a growing body of evidence of what works, for whom, under what circumstances.

From the evidence, what will enable successful commissioning at the delivery, monitoring and evaluation stage?

	Shorter-term	Longer-term
Ministry of Health	Build measures and performance monitoring of the reform's intent, including evidence of: service integration Budget Bids which prioritise prevention	Monitor and report on: increasing transfer of health funding to prevention, including public and population health Māori health and wellbeing and health inequity improved service integration
Public Health Agency	Prioritised work programme focusing on system-level levers to improve public health	Increasing use of system levers (eg regulation) to create healthy environments as part of embedding active protection Te Tiriti o Waitangi principle
HQSC	Guidance on how to improve service design and delivery from a health and safety perspective	Build understanding of health and safety within a Te Ao Māori framework, to help build provider and funder capability
Health NZ	Work with MHA to use Te Ao Māori framing in evaluations and public value assessment Review BAU services, to identify and remove waste in the system Support innovation	Monitor and report on: • progress in shifting funding to prevention • Māori health and wellbeing • reduced health inequity • improved service integration • improved cross-sector collaboration

Māori Health Authority	Monitor the quality and robustness of outcome measures, frameworks and performance monitoring	Support capability building in monitoring and evaluation Identify where other levers are needed to support commissioning (policy, regulation)
Iwi Māori Partnership Boards	Support performance management, monitoring, evaluation and continuous improvement design Provide insight and context to reports Provide guidance on when decommissioning is needed and how to manage this to minimise service continuity, impact on people, providers and provider markets	Identify and prioritise areas for capability building in performance monitoring, evaluation, continuous improvement and decommissioning Provide insight on kaupapa Māori provider markets, and areas for investment and capability building Signal changes in context and emerging issues and opportunities
Social sector	The Social Sector Commissioning work programme develops an investment strategy for social sector NGOs, kaupapa Māori providers and other community providers, to build the data and digital infrastructure to reduce compliance costs and improve data quality	The Social Sector Commissioning work programme manages the implementation of the social sector provider capability build Review the impact of commissioning across health and social sector provider markets, and guidance on how not to disrupt effective local services and networks
Te Puni Kōkiri	Te Puni Kōkiri develop a workforce investment strategy with the Māori Health Authority, IMPBs and Social Sector commissioning to build the workforce needed to bring Te Ao Māori framing to co-design, economic analysis, sourcing and investing, evaluation and change management	Scholarships, mentoring and internships are used to build the Te Ao Māori commissioning workforce, with a focus on attracting people with lived experience and understanding of trauma informed support
Min. Pacific People	Ministry of Pacific People develop a workforce investment strategy with the Māori Health Authority, IMPBs and Social Sector commissioning to build the workforce needed to bring a range of pacific framing to co-design, economic analysis, sourcing and investing, evaluation and change management	Scholarships, mentoring and internships are used to build the Pacific commissioning workforce, with a focus on attracting people with lived experience and understanding of trauma informed support
ACC	Support insights on pathways to effective prevention, treatment and rehabilitation Support the development of datasets that help connect outcomes to providers and contracts across the health and social sectors	Contribute to insights on what works (for different communities, contexts and types of preventable injury and harm) Support investment strategies to meet current and projected demand.
Treasury	Te Ao Māori framing of public value is developed and tested Develop and report on the 'cost of late action' as a way of measuring system performance (amount of funding directed to avoidable services, eg childhood obesity, Oranga Tamariki, youth justice)	Budget is released to support investment in the contract and provider data infrastructure to allow system costs and public value assessments across the health and disability sectors Budget is released to build the commissioning workforce The Budget Bid processes supports an increasing shift across the system to prevention.

Appendix 5: Commissioning case studies

Completed	Case study purpose	Insights and future application
Purpose	1 Capturing insights from **Te Pūtahitanga o Te Waipounamu (South Island Whānau Ora Commissioning Agency)** in innovative commissioning approaches, where whānau are supported to develop localised solutions. The case study also sets out the broader evolution of Whānau Ora from a provider-based response to a collective, then a commissioning agency.	The aim is to distil and **transfer insights from Whānau Ora's implementation and evolution**, so the health and disability system can learn how to support whānau on their health and wellbeing journey in ways that matter to them.
Understanding	2 **Te Ranga Ora** in Counties Manukau shows a community-initiated response to treating and preventing long-term conditions, like diabetes and heart disease. Counties Manukau Health now supports five distinct community-developed prototypes, all in different stages of operation.	The Te Ranga Ora case study highlights what is needed to support **community-initiated responses** at the design stage, as well as how to retain community leadership once services are operational.
Planning and designing	3 Designing the journey of system transformation in the disability sector to enable people to live good lives, looking at **Mana Whaikaha** in Palmerston North.	The Mana Whaikaha case study looks at **flexible funding** as one of the first key steps to enabling disabled people choice in what services and support they receive as part of their care. This needs to be supported by changes in mindsets (ie recognising that disabled people know what is best for themselves), workforce training and leadership.
Sourcing and investing	4 **District Health Boards** are the main commissioners for health and disability services in their areas. Examples of equity-focused commissioning of services are captured from four DHBs (Lakes, Mid-Central, Hawkes Bay and Tairāwhiti).	These DHB case studies will highlight different approaches used, at the local and regional levels, with a focus on **community-led and whānau-centred services**. Perspectives will be shared from both DHB and providers.
	5 The Ministry of Health's **Mental Health Directorate** used innovative approaches to procurement, eg video applications in te reo Māori, to help encourage new kaupapa Māori providers into the mental health sector.	This case study shows how innovation in procurement can help **attract new kaupapa Māori mental health service providers** and improve **service options for whānau**. *"Innovation in procurement practice is the most likely path to innovation in service delivery"*
Delivery	6 Most of the barriers to medicine adherence are created by the way the health system operates. Poor medicine adherence has a greater impact on people with long-term conditions, Māori, Pacific people and rural/remote communities, **ZOOM Pharmacy** combines understanding consumer preference, removing barriers to access and supporting medicine adherence.	The ZOOM Pharmacy case study focuses on the interaction between a commercial entity and social entrepreneur and the health system, to understand how **to harness entrepreneurial responses which improve equity** while meeting system stewardship obligations.
Monitoring and evaluation	7 Greater cross-sector collaboration is needed to address inequity in health and wellbeing. The **National Telehealth** services is a long-term cross-sector contract to create a flexible telehealth environment that can evolve and respond to new opportunities and changing contexts (eg Covid).	The National Telehealth case study focuses on what was needed to support **cross-sector commissioning over a long time period** (10 years), what benefits has it produced, and lessons for the future.
	8 **Healthy Families NZ** takes a cross-sector and community development approach to improving health and wellbeing. It focuses on building capacity and resilience within communities to prevent long-term conditions like diabetes.	The Healthy Families case study provides insight into how to commission and report on the **collective impact of working with communities, NGOs, providers and mainstream services** to prevent long-term conditions. The focus is on building the 'core economy' of family, whānau and community, to complement traditional service-based responses.

Appendix 6: Commissioning learning partnerships

Focus	Learning partnerships;	MHD role	Learning partners: Māori Health Policy and…
Innovation	The Te Ranga Ora (TRO) learning partnership will assess the effectiveness of five community-initiated prototypes in treating and preventing long-term conditions (LTCs) with a whānau-focus. The Turuki Health Mobile Outreach contract recreates the permissive contracting environment used during the Covid-19 nationwide lock down in 2020, supplemented with an agreement to extract data on actual service provision (rather than narrowly prescribe services, when demand is unknown).	Influence Lead	Population Health & Prevention Te Ranga Ora prototypes Counties Manukau Health Kaupapa Māori service providers
Addressing gaps	Tamariki in contact with Oranga Tamariki (OT) have the lowest enrolment with GPs and are more likely to have missed key health checks (eg Before School) than any other group of children. The Māori Health Directorate were asked to take a pragmatic response to this issue by its external Māori Advisory board. Amid wider system and service improvements, this initiative is focused on what can be done now to ensure primary health care services reach tamariki in contact with Oranga Tamariki and their whānau. Understanding how this group fall between existing commissioned services will be the first step. The discovery phase may provide sufficient insights to guide action, but a protype may be needed to test options.	Lead *(discovery phase)*	Oranga Tamariki
Strategic investment	How to be a good commissioner of kaupapa services and mātauranga Māori Capture insights from the Māori Health Directorate's Māori Health Services Improvement team on how to strengthen kaupapa Māori services and mātauranga Māori through commissioning, including contracting and reporting requirements. These insights will be consolidated with research from Māori providers' perspectives, drawn from the literature (eg Te Piringa) as well as testing with a sample of providers, and developed into a practical guide.	Lead	Māori Health Services Improvement team Kaupapa Māori service providers
	Population Health and Prevention's Investing in Wellbeing Over the next two years Population Health and Prevention's **Investing in Wellbeing** work programme will explore different ways of commissioning to: • improve wellbeing outcomes for Māori, Pacific people and those living in areas of economic deprivation; and • strengthen provider innovation and develop and spread effective kaupapa Māori and whānau-centred services. Contracts with national service providers will be reviewed and around $11m health promotion funding currently directed to services for nutrition and physical activity, alcohol and other drugs reinvested.	Influence	Population Health and Prevention Māori Health Services Improvement team
System enablers	Enabling innovation within existing procurement and contracting environments There is often more scope for innovation within existing legislation and procurement rules, but practices have normalised narrower interpretations. What can be done now is to ensure procurement advisors and contract managers are part of the journey of supporting innovation in service and system design, as well as providing expertise on how to meet accountability requirements.	Co-lead *with MOH procurement*	*Initially* Ministry of Health Procurement MSD Social Sector commissioners
	Learning from and contributing to the wider Social Sector commissioning programme Learning from and contributing to the wider Social Sector Commissioning work programme, noting the importance of the social sector to addressing the broader social, economic and behavioural determinates of health. The consultation process has now ensured te Tiriti of Waitangi is the starting point of transforming social sector commissioning. Work is now underway to change behaviour, practice and systems to improve outcomes for whānau and communities.	Influence	*Later* Treasury Ministry of Business, Innovation and Employment.

DRAFT Not Government policy

NOTE: This is a working draft.

The Framework is also being designed with a web-portal in mind, so people can navigate to the area they are interested in, with links to guide, tools, cases studies and videos describing innovations and outcomes.

Systems Framework for Pae Ora Commissioning

A te **Tiriti o Waitangi grounded** commissioning framework to deliver **health equity and wellbeing** outcomes that **matter to whānau**

October 2021

Māori Health Directorate

Ministry of Health

Contents

PURPOSE

The Pae Ora Commissioning Framework sets out:

- **WHY** we need to change the way we commission, to improve health and wellbeing outcomes for Māori (and for other groups too)
- **WHAT** we need to change
- **HOW** we need to change, and how we'll know that what we've done works for whānau.

The Framework sets out how each stage of the commissioning cycle can be used to improve outcomes for Māori. Key questions, links to other guides, tools and resources are provided.

The Framework is iterative and will be updated to reflect new understanding and insights on:

- what matters to whānau
- what outcomes are meaningful for whānau
- what works for whānau.

Ideas for short-term and longer-term action for key participants in the health and disability sector, and the social sector are suggested, noting these will need to be considered, further developed and agreed by the entities being formed; the Māori Health Authority, Health NZ and the Public Health Agency.

Commented [JO1]: He tangata, He tangata, He tangata

1. WHY COMMISSIONING NEEDS TO CHANGE

The way we commission services impacts whānau wellbeing and equity and we must do better. Outcomes for Māori won't change unless we change the way we think, act, fund, deliver and assess outcomes when we commission.

Commented [JO2]: Comments section is being used to show where quotes and sidebars will be added in the document design.

What is commissioning?

Commissioning is an approach to understanding what outcomes are wanted, then planning, designing, implementing and managing a system to deliver these outcomes in the most effective way.

Commented [JO3]: Commissioning requires shifting from managing inputs and outputs to managing for outcomes.

Commissioning is much more than procuring services. It requires deeply understanding '**what matters to whānau'**, and then working with them to design services that address their needs and build on their strengths.

Commented [JO4]: Procurement focuses on finding the right provider and developing contract and funding terms that will help deliver the outcomes wanted. It's the technical and legal part of the much the broader strategic commissioning process.

The key commissioning stages are:

1. Purpose and understanding
2. Designing and planning
3. Sourcing and investing
4. Delivering, monitoring and evaluating
5. Reviewing and adapting.

These are repeated, building in new insights on '**what works for whānau'** and responding to changing contexts.

Who commissions in the health and disability sector?

Following the Health and Disability Reforms:

- Strategic-level commissioning will be one the tools available to the stewards of the health system – the **Ministry of Health and the Maori Health Authority** – along with policy, regulation, performance monitoring and evaluation to improve overall health, wellbeing and equity
- Health NZ and the **Maori Health Authority** will take over the commissioning of services and interventions previously carried out by the Ministry of Health and DHBs, and be supported by locality networks and **Iwi Māori Partnership Boards**.

Figure 2: Levels of engagement by key health and disability sector entities, now and in the future

Level	Until July 2022	From July 2022	
National	Ministry of Health and it's commissioning directorates	Ministry of Health Public Health Agency	Maori Health Authority
		Health NZ	
Regional	District Health Boards	Health NZ	Maori Health Authority
Local	District Health Boards	Health NZ	Iwi Māori Partnership Boards
		Locality networks	

- Features specific commissioning and co-commissioning are set out for:
  - hospital and specialist services
  - primary and community care
  - public health, in particular the focus on population health and determinants, which points to much stronger focus on cross-sectoral collaboration, including a more joined up approach to policy, strategy, and commissioning/co-commissioning, or at least integrated/aligned commissioning where agencies ensure that what they are commissioning is complementary.

A unifying commissioning framework can be applied across public health, primary and community care and health and specialist services, noting there will also specific requirements for each (eg a different order of capital investments for hospital and specialist services).

Commissioning can also be done by, and on behalf of, whānau

The health and disability system can allocate resources directly to individuals, whānau and iwi to exercise rangatiratanga over what services and support are purchased when, how and from whom. This is a key element of the Enabling Good Lives approach, and can have a profound positive impact on people's and their whānau's lives. This approach is also used in the social sector through Whānau Ora.

Commented [JO5]: See Appendix 1 for the structural changes once the reforms have been implemented, and the aims of the reforms,

Commented [JO6]: Health NZ and the Public Health Agency will span national, regional and local levels of operation. The Māori Health Authority will operate at the national and regional level, and partner with Iwi Māori Partnership Boards and locality networks at the local level.

Commented [JO7]: See Case Study 3 on Mana Whaikaha's flexible funding a part of disability system transformation.

Commented [JO8]: See Case Study 1 on Te Pūtahitanga o Te Waipounamu (South Island Whānau Ora Commissioning Agency).

When is commissioning done?

The commissioning process can be initiated as part of annual and strategic planning, reviewing services or contracts and responding to changes in context:

Planning	• as part of investment strategies and annual budget setting • when undertaking strategic planning • when reviewing an agency, or cross-agency, priorities
Reviewing	• ahead of contract renewal considerations • following a review of services or programmes
Responding	• when considering service continuity in the face of increased demand, workforce constraints, provider exit, markets constricting • when something unexpected happens, like a global pandemic.

Why focus on commissioning?

The way government agencies commission can have a profound impact on kaupapa Māori and mainstream service providers, and government relies on a sustainable provider market to provide accessible, effective and culturally safe services.

When done well, commissioning for pae ora will help:

Whānau	• improve health and wellbeing • improve access to timely, quality, culturally safe health care • build understanding of '**what matters to whānau'**
Providers	• identify gaps in current services (type, mix, location, hand-overs) • deliver new services and models of care including mātauranga Māori and the full range of rongoā Māori services • better integrate and coordinate services across health and social sectors
Funders	• innovate to meet needs, build strengths and adapt to changes (strategic priorities, context) • learn how to devolve decision-making and funding • build diverse, sustainable service kaupapa Māori provider markets • build and develop a diverse and sustainable sector workforce
System	• build evidence of '**what works for whānau'** across the health and social sectors • direct resources to where they will have the greatest impact and deliver public value • put in place system enablers and reduce system barriers to achieving outcomes • reduce health and wellbeing inequities.

Commented [JO9]: Why commission?
OECD research [1] has shown how classical public administration practices worked well when operating environments were relatively stable, and issues were slower moving. As the pace of change started to increase, New Public Management approaches sought to drive efficiencies through deregulation and competition. As the global economy and pace of technological advances and inequities, grow, a new way of working is needed. New Public Governance, uses collaboration and innovation to improve efficiency and quality of services and systems.

Commented [JO10R9]:

Commented [JO11]: COVID-19 responses
In responding to COVID-19, iwi, hāpu and Māori collectives played a significant role in supporting Māori and the wider community in their rohe, showing agility to mobilise and organise effectively.[1] Their ability to act quickly came from the deep connections and relationships of trust they have built. They were also unfettered by multi-layered approvals processes; they could just get on with the mahi. The permissive contracting environments allowed Māori to work their way. The success showed what happens when Government share power - a key to building successful commissioning systems.

Commented [JO12]: Contracts that do not cover the true cost of delivery, are small and/or short-term results in providers seeking additional contracts, often across multiple funders and funding pools. The resulting 'patchwork' of funding sources carries a high compliance burden to both apply for funding then meet the array of accountability and reporting requirements. As an example, one Māori provider has over 40 separate contracts to deliver different health and wellbeing services.

Commented [JO13]: A range of providers can be commissioned to provide health services and support, so long as they meet regulatory requirements and standards. Some are commercial entities (eg most pharmacies and general practices). Regardless of whether a profit is made, all providers have to balance the costs of providing a service, as well as the ability to recruit, train and retain staff. Tight, time-limited funding can mean NGOs lose skilled staff to better paid, more secure jobs in government agencies.

2. OUR KAUPAPA

The way we commission services is impacting on whānau wellbeing and equity. The current commissioning process creates systemic barriers:

- for people and whānau accessing services, and
- for Māori providers to start up, access funding, innovate and become sustainable.

Under Whakamaua: Māori Health Action Plan 2020-2025 a key objective is to strengthen commissioning frameworks and guidance to increase Māori provider innovation and develop and spread effective kaupapa Māori and whānau-centred services. This focus is on primary and community services.

What makes this commissioning framework different?

We have many commissioning frameworks across our motu. Many of our Iwi Māori providers have their own frameworks. Three areas of difference for this framework are:

1. ensuring '**what matters to whānau**' is the first question at every stage of the commissioning process; whānau are always 'at top of the page'
2. enabling Māori to exercise **mana whakahaere, mana motuhake, mana tangata and mana Māori**
3. **ako** learning together '**what works for whānau**' at every stage of the commissioning cycle, and using this to improve the system and services.

	Commissioning for pae ora
Te Tiriti o Waitangi	• It is grounded in Te Tiriti o Waitangi principles • Whakapapa back to Puao-te-Ata-tu, Te whare tapa whā, Whānau Ora, Wai25 and Te Puni Kōkiri's Te Piringa research on bringing the Whānau Ora vision int primary care
What matters to whānau? self-defined; by whakapapa, by aroha, by kaupapa	• Starts with '**what matters to whānau**' to shape commissioning at every stage where they are always 'top of the page'. • The diversity of whānau is recognised • Non-clinical aspects of care including rongoā Māori and mātauranga Māori ar valued as well as clinical aspects.
System, strategic and service levels	• Takes a broader view of commissioning and covers system impacts, strategic commissioning, surveillance of health and disease, sustainable funding and workforce, provider capacity and capability, data and digital, and market shap alongside the more usual focus on commissioning services
Māori world view, leadership and decision-making	• It builds for the future, with the aim of devolving decision-making and fundin enabling environments are created for Māori to exercise mana whakahaere mana motuhake, mana tangata and mana Māori
Government requirements enable Te Ao Māori approaches	• Government requirements mature so they enable Te Ao Māori approaches to commissioning • Funders and providers demonstrate how innovation fits within current Government requirements
Ako *we learn together*	• Recognises we are all learning together to understand '**what works for whānau**'; from service users, whānau, communities, Māori service providers, iwi Māori Partnership Boards and stakeholders across the health and social sectors, including Whānau Ora. • Insights will be used to improve not just service design, but also the overall system.

Commented [JO14]: Quote: Many of our people are not engaging with the system – the **system doesn't work for them** and they stand to lose a lot. *Hui Whakaoranga 2021*

Commented [JO15]: **"I don't bother** with the health, justice or social funding because of the process"- *A Māori drug and alcohol service provider*

Commented [JO16]: "Māori providers are **over-audited** and heavily scrutinised and are **excluded** from the request for proposals processes. *Hui Whakaoranga 2021*

Commented [JO17]: Whakamaua: Māori Health Action Plan 2020-2025 is the implementation plan for He Korowai Oranga, New Zealand's Māori Health Strategy. It outlines actions that will help to achieve four high-level outcomes:
- Iwi, hapū, whānau and Māori communities exercise their authority to improve their health and wellbeing.
- the health and disability system is fair, sustainable and delivers more equitable outcomes for Māori.
- Racism and discrimination is addressed in all its forms.
- mātauranga Māori is protected throughout the health and disability system

Commented [JO18]: •Mana Motuhake: the right for Māori to be Māori, to live on Māori terms, values and practices including tikanga
•Mana tangata: equity in health and disability outcomes
•Mana Māori: Ritenga Māori (rituals) framed by te ao Māori, enacted through tikanga and encapsulated within mātauranga Māori (Māori knowledge).

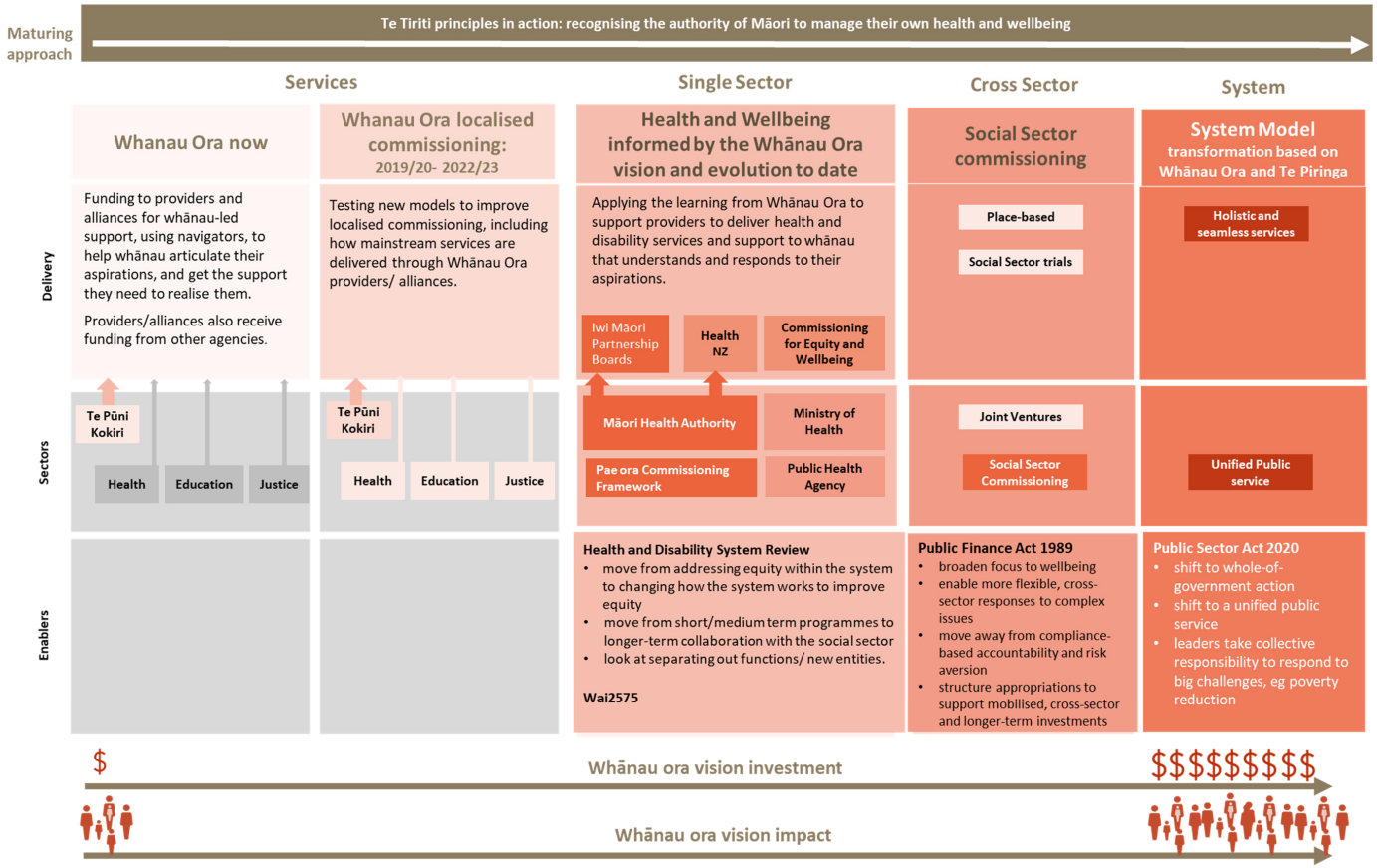
Commented [JC19]: In line with the NZ Health and Disability System Review report, released in March 2021, what would the commissioning system look like if public and population health is at the centre of the new health system? Would it be more investment in prevention and upstream approaches, and tackling the wider determinants of health and wellbeing through cross-sectoral collaborations and collective accountability of the investment and outcomes of health, wellbeing and equity.

Commented [JO20]: https://www.tpk.govt.nz/en/a-matou-mohiotanga/health/te-piringa-whanaucentred-primary-health-care

Commented [JO21]: For Māori, this incudes whakapapa: *Kia whakatōmuri te haere whakamua.* I walk backwards into the future, with my eyes fixed on my past

Expanding the whānau ora vision

Enabling environments have changed, which means the whānau ora vision can now more easily expand into the health and disability system, and across the broader social sector.



What are we aiming for?

Figure 1 shows what maturity looks like for each of the participants in the commissioning process. We all need to work together. The journey will take time, and trust, but every small step helps.

	Current state	1-2 years	3-5 years	10 years
WHĀNAU 	Get what the system thinks they want Are seen as passive recipients in their health and wellbeing journey Seen as 'problems to be solved'	Can exercise choice over what service and support they use Enabled to be active participants in their health and wellbeing journey Services work with the whole whānau	The right support can be accessed easily, and early on: - in life, and - in the life of a problem	Experience seamless access to whānau-centred services across the life course Strong health literacy 'Core economy' of people, whānau, community is strengthened; social connections rebuilt and flourish
PROVIDERS 	High compliance costs across piecemeal contracts Funding approaches make it hard to attract, train and retain staff	Deeply understand the community and context Whanaungatanga and building strong, trusted relationships is valued Co-produce whānau-centred, culturally safe services	Continuous improvement includes clinical, cultural and community insights Innovation embedded Can attract and retain skilled workers	Enabled to work collaboratively with other services Leadership supports innovation and adaptive management; services and staff can flex to meet new challenges and opportunities
FUNDERS 	Low trust Outputs focused contracts Deficit and disease focused Siloed approach Application process favours larger providers with good bid writers	Contextualised understanding Enable high trust relationships and encourage innovation Process supports diverse provider pool Contracts support outcomes Monitoring builds insights	Take a capability building approach; for providers, and for whānau and community Collaborate across the social sector, and collective accountability Funding and other support to ember innovation	Devolved funding and decision-making Broader provider pool get funding Whānau outcomes and innovation are incentivised Health, wellbeing and equity outcomes improve
SYSTEM 	Lack of clarity of roles and purpose, leading to gaps, overlaps and wastage Problems need to escalate to reach thresholds for action	Investment focuses on prevention and broader determents of health and wellbeing (causes, not symptoms) Workforce pipeline to meet changing demand, collaborative working and outcomes-focus		Investments are guided by evidence, te Tiriti principles, whānau voice, robust data and forecasts. "Wastage', and human and financial costs are reduced as system agents work well together Sustainable investment and effective workforce pipeline

3. WHAT WE CHANGE

Conventional commissioning

Conventional commissioning starts with the system holding the power and decision-making rights, and assuming it knows best about what works for whānau. Conventional commissioning uses contract specification to manage risks; it sets out clear expectations of what providers need to deliver.

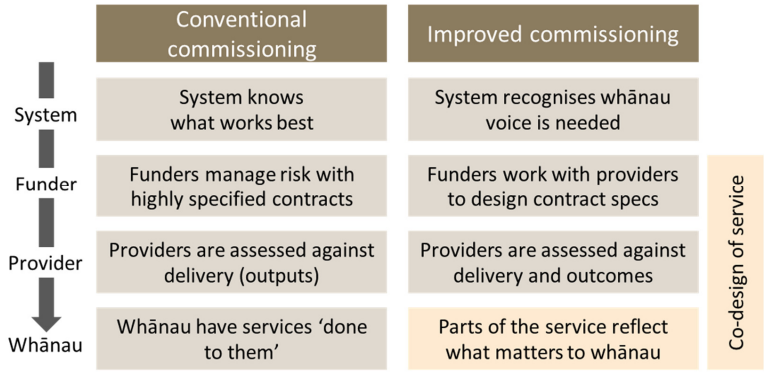
Often contract amounts are below the actual cost of delivery, leaving providers reliant on more funding/work to keep afloat, and little headroom to innovate. This is because funders have tended to focus on what they can control, so look at low unit costs as a way of being fiscally responsible. But what is needed (and more important) is thinking about costs across the system, delivering what works for whānau and public value.

In the past, contracts tended to be largely transactional and done at arms-length; commissioners told the providers what they wanted, and how to measure what was done. There was also a tendency to focus on monitoring outputs. In part this is because Government agencies can more easily control and track outputs, and measuring outcomes and attribution is hard. In the health sector this reinforce a disease and deficit approach as it's easier to measure what was delivered, fixed or cured.

Providers would then be required to spend a lot of time collecting and reporting on what they've done, but in a way that didn't add value to them, or funders – it was just for contract compliance.

Understanding has grown that relational approaches to commissioning achieve better results that transactional approaches, as commissioners work with providers to understand what is possible. Over recent years there has been an increased involvement in seeking whānau input into service co-design, noting a high variance in practice and fidelity to co-design principles. But what is missing is a system's approach which helps build in good practice from innovation and whānau insights, improve consistency of application and embed improved services and practices into business as usual.

Figure 1: Conventional commissioning



Commented [JO22]: When it comes to a highly specialised and regulated services like surgery, this is an appropriate assumption. (We are not suggesting a move to do-it-yourself surgery!). But even in services like surgery, whānau voice can still shape non-clinical aspects of the service, like having specialist appointments grouped together, culturally safe practice and consideration of other supports, eg childcare, in home care.

Commented [JO23]: Examples of this are part-payment fees in primary care leading to escalation of problems, then use of no-fee emergency services. Or the lack of 24 hour care for people in mental health crisis being picked up by other sectors, eg Police.

Commented [JO24]: Attribution is where the outcome can be clearly linked to the service, intervention or treatment provided.

Commented [JC25]: Attribution is especially hard when assessing public health interventions. Mixed methods of qualitative and quantitative measures that are meaningful and useful can be developed with providers and communities and measured over time.

Commented [JO26]: A challenge for services or interventions that focus on prevention or improving wellbeing is how to demonstrate impact. More sophisticated approaches to measuring outcomes are needed, with comparisons over time or against matched groups who did not receive the service or intervention. There are also issues of intensity and scale of the intervention and the ability to control for other variable that might influence the outcome.

Whānau and Māori-led commissioning

Whānau and Māori-led commissioning turns conventional commissioning upside down – it starts by deeply understanding **what matters to whānau**, their communities and context.

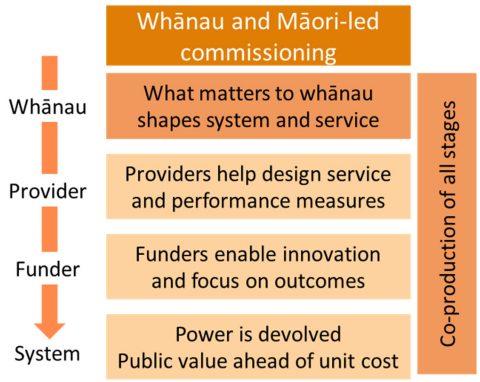
Providers' expertise is used to design performance measures that create insights which help drive continuous improvement. Funders enable innovation and ensure the focus stays on the outcomes achieved. Power is devolved, and public value – and system costs – replace the inward, narrow and distorting focus on unit costs.[1]

At the strategic and service level, commissioning aims to increase the choice, agency and control whānau can exercise – in other words, commissioning enables tino rangatiratanga and options.

Commented [JO27]: System costs consider the impact of not doing the right thing at the right time;
- needs escalate as people churn through the system
- Costs are shifted to other sectors – eg poor quality housing creates avoidable health treatment of respiratory illness.

Commented [JO28]: These changes have been demonstrated to improve health and wellbeing, reduce human costs, and the cost to the system.

Figure 2: Whānau and Māori-led commissioning



Appendix 2 sets out the range of shifts that are needed to move from conventional commissioning to commissioning that is whānau and Māori-led, along with system conditions and enablers needed to embed successful innovation into business as usual.

[1] Add references: Vanguard, Sydney lab etc

What we need to do differently

Outcomes for Māori and other groups poorly served by the current system won't change unless we change the way we trust, think, plan, act, fund, deliver and assess outcomes when we commission.

	Conventional commissioning	Whānau and Māori-led commissioning
Whānau	• Barriers to accessing health care are created as whānau needs, capability and context are not understood • Propagates a power imbalance as professionals decide what's best for service users and whānau	• 'What matters to whānau' shapes system and service design • Whānau are seen as having strengths, social capital and capability • Whanāu are enabled to exercise choice and decision making for their own health and wellbeing.
Providers	• Services are only enabled to treat symptoms, conditions and people in silos. • Funding is easier to secure for services with a western bio-medical approach • Innovation is restricted as funding comes with highly specified deliverables • Funding levels are often below cost of delivery • Multiple contracts are needed from to stay afloat.	• Services are integrated and multi-disciplinary teams take a holistic approach, 'working with' people and their whānau. • Root causes can be addressed with a focus on determinants of wellbeing, and strengths built. • Funding can be secured for the full range of rongoā Māori healing practices • Innovation is enabled as contracts support development of new approaches using co-design. • Funding levels cover the cost of delivery and sustainable. • Funding is pooled/integrated and/or reporting compliance costs reduced.
Funders	• Contracts and performance measures focus on outputs and embed a disease and deficit approach, as these are easier to track • The process to apply for funding is onerous and reporting is rigid in approach • Contracting practices have narrowed what is really possible within existing rules. • Focus is on unit cost and short-term efficiencies	• Focus is on outcomes, with evidence-based theories of change on what is needed, including funding, time and other resources. • Contracts and performance measures track fidelity to evidence of what works, and contributions to the 'journey' and broader, more sustainable outcomes are valued. • Funding applications are streamlined and short term (time limited) one-off investments to support innovation can be approved using a 'lighter' business case, aligned to the level of risks identified. • Reporting is developed with providers, to ensure measures contribute to continuous improvement. • Innovation within existing rules is encouraged. • Thinks about costs across the system, with a focus on prevention and long-term public value.
System	• Separated roles: service users seen as passive, service expectations rest with the provider and funding decisions made by the funder.	• Collective or shared accountability through joint decisioning-making, including funding allocations (through Iwi Māori Partnership Boards.)

System conditions	• Western bio-medical models and clinical perspectives are privileged • Professionals are experts, and 'do to' service users and whānau • Services break people into problems to be fixed • Structural and systemic racism influences investment decisions • Productive efficiency valued (unit cost) • Treasury and the Ministry track funding and investment by service lines (eg, tobacco control, alcohol and other drugs, nutrition and physical activity, etc) which limits thinking, and opportunity for more strategic investment • Inward-looking focus on health sector	• Mātauranga Māori and rongoā are valued. • Whānau are experts in what works for them, and their insights shape system and service design • Professionals 'walk alongside' whānau, and enable choice and control • Structural and systemic racism are called out and addressed • Allocative efficiency valued (whole of system cost, including costs borne outside of the health sector) • The Ministry (supported by Treasury) re-shape Purchase Unit IDs to track funding by core functions to support more strategic investment (see Public Health approach). • Connects to wider social and economic sectors
Enablers	• There is no easily accessible data on providers or on the contracts they receive, within health, let alone other sectors. • Low capacity and capability in commissioning skills; commissioning seen as contracting third party providers.	• Provider, contract and reporting data infrastructure is developed and actively used. • Build people and teams so the broad range of skills needed for effective commissioning are available, both nationally and locally: engagement, analysis, prioritisation, contracting, relationship management, monitoring, continuous improvement

	How we commission for pae ora: changes in how we think, act, fund etc
Trust	• Commissioners need to invest in relationships with providers and potential providers • Time is needed to allow whānaungatanga and build relationships of trust • At the start, trust needs to be built on a clear foundation of the purpose of the relationships, any non-negotiables and external requirements (eg, legislation, Budget processes and requirements, Ministerial expectations) • Other pre-conditions also need to be clearly communicated. • Trust is maintained with open and timely communication, flexibility when responding to emerging issues or opportunities, and having each other's back when things don't go as well as planned.
Think	• **Te Tiriti principles** reflect what works when commissioning for better and enduring outcomes • Te Ao Māori contains kawa (knowledge) and tikanga (ways of working) that will improve outcomes • Whānau have strengths and capabilities • **'What matters to whānau'** shapes system and service design, delivery and improvement • We are accountable to Māori
Act	• We need to work together, and trust needs to be rebuilt between whānau, communities, providers and funders • We will be learning partners, and find out what we need to do better • We will challenge the status quo and do new things - this will feel uncomfortable for many (and mainstream) and a relief to others as we finally do what Māori have been wanting for decades • We'll work to manage risks, and our leadership teams will have our backs
Fund	• Funding shifts to focus on: - 'what matters to whānau'; the change isn't real until this happens - prevention (active protection) over time; the change is real until this happens • We commission for a longer term and stop doing lots of small contracts which don't cover true costs of delivery and take providers away from their real work to meet reporting requirements that don't add value
Deliver	• We enable services to become more holistic, collaborative and integrated • We enable providers to practice **mātauranga Māori and rongoā Māori** • Services deliver what matters to whānau, and are enabled to stop doing things that aren't
Assess	• Outcomes measure what is **meaningful to whānau** • Providers shape monitoring and accountability requirements with funders, so useful information is reported and helps support continuous improvement • **Te Ao Māori outcomes framework and kaupapa Māori research** builds understanding of what works and why • Theories of change and measures of public value support bids for sustainable (not just prototype) funding, and demonstrate better outcomes from commissioning for pae ora
Improve	• The evidence of **'what works for whānau'** reshapes services and future investments • We can re-shape or stop services that no longer deliver what matters to whānau, and use clear processes with good lead-in times so providers are not put at risk • Over time funding moves upstream, to prevention • We identify where other levers are needed, eg regulation (eg to address food environments)
Build	• We build teams with the technical skills and whānau and community engagement skills to commission well, including understanding of **Te Ao Māori, tikanga and te reo** • We take time to build and maintain relationships, and budgets to allow more kanohi ki te kanohi meeting

Commented [JO29]: For example, if an aim is to demonstrate the impact and/or social cost benefit, initiatives need to be delivered with enough intensity and/or duration to enough people to allow meaningful comparison (either the same people before and after, or with matched comparison groups or propensity analysis). Time is also needed for the numbers to build the numbers needed, and allow outcomes to be achieved.

Commented [JO30]:
Good commissioning
- supports **tino rangatiratanga** by enabling choice, control and autonomy of decision-making for whānau
- improves **options** for whānau by having a range of accessible, culturally safe and effective services and supports, facilitating choice
- builds **partnerships** through investing in effective and accessible kaupapa Māori service providers and supporting resilience in provider markets
- creates **active protection** by building the capability of people, whānau, providers and communities, and influencing the conditions which contribute to health and wellbeing
- …. and these combine to improve **equity** of health and wellbeing outcomes, by responding to people in the context of their whole selves, and their whānau and community contexts.

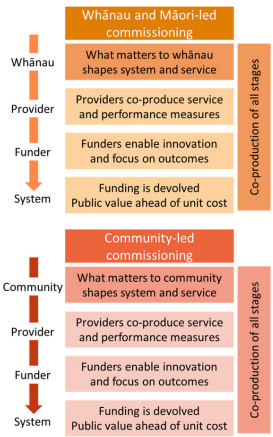
Commented [JO31]: Te Tiriti, equity and needs analysis, co-design, service design, prioritisation, procurement and contracting, risk management, monitoring and evaluation, continuous improvement, decommissioning and change management.

	• We develop tools and resources with providers that help them meet accountability and reporting requirements with minimal effort • We understand gaps in the provider market, and actively build existing kaupapa Māori providers' capacity and capability, as well as support new providers as they set up.

Commissioning frameworks in the new system

The Pae Ora and Commissioning for Equity and Wellbeing Frameworks have two key aspects:

- there is a primary focus on what works for people and whānau, rather than prioritising what the system does; and
- they support cross-sector work, and the focus on enduring improvements for people, whānau and communities embedded in the Public Services Act (2020) and the Public Finance Act wellbeing amendments.



Pae Ora Commissioning Framework to guide current commissioning and provide potential insights for the Māori Health Authority and Iwi Māori Partnership Boards to help:

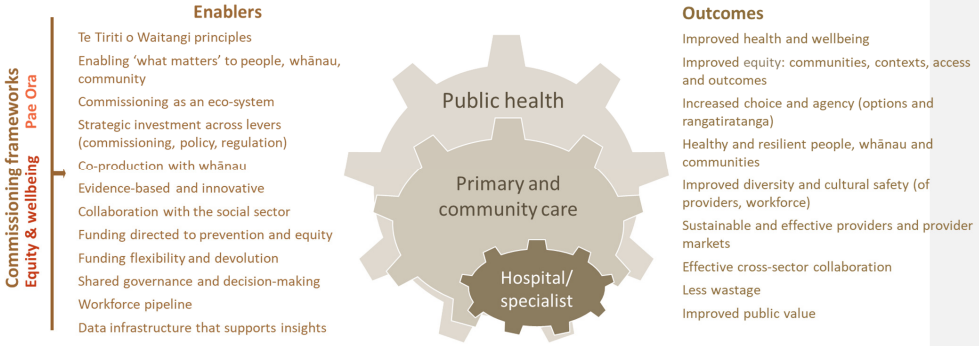
- improve the commissioning, and co-commissioning of health investments in collaboration with Health NZ and wider social sector agencies
- remove barriers to entry and sustainability for kaupapa Māori providers
- improve the capacity and capability building of kaupapa Māori providers
- understand what is needed to align work across the wider social sector to improve outcomes, including cross-sector commissioning, investment in provider capacity and capability and strategic (rather than reactive) provider market shaping.

Commissioning for Equity and Wellbeing Framework to:

- help guide the Ministry of Health in its current role as commissioner, and its future role (along with the Māori Health Authority) in monitoring Health NZ and the MHA's commissioning performance and results. This includes understanding key enablers (workforce, data and digital, performance monitoring and continuous improvement).
- provide guidance to the Public Health Agency on how the mix of levers (regulation, policy, commissioning and monitoring and evaluation) can be aligned to create stronger interventions

Commissioning frameworks that can be used across all investments

A benefit of the commissioning frameworks developed by the Ministry is that they can be applied to public health, primary and community care and health and specialist services, noting there will also specific requirements for each (eg a different order of capital investments for hospital and specialist services). This could help provide a common approach to embedding Te Tiriti principles and a focus on more enduring and broader health and wellbeing outcomes across different parts of the health system. Going forward, the common approach could support insights and collaborative approaches to investments and awareness where other levers are needed.



Appendix 2 shows how the framework can also be used for planning investments across the life-course, for different types of investments, and across the broader social sector.

Developing Models of Care as an example of a product of the commissioning process

Models of cares set out best practice and services or response for a person or group as they progress through a condition, injury or episode of care. A model of care is not limited to health and disability services; it may include social and cultural services that support the delivery or outcomes of health care. [2]

Designing for success

The model of care will drive how the service is designed and delivered, so it must be an evidence-informed, agreed model that will meet the needs of the people, whānau and community identified.

Other factors which contribute to designing for success are shown below.

	To be successful, models of care need to:
Whānau	• ensure service users and whānau shape the purpose • takes a holistic approach to pae ora and includes services outside the health sector • ensure services are accessible, affordable, high quality, culturally safe and effective
Providers	• have service delivery that is underpinned by a robust framework that reflects clinical and non-clinical aspects of care • focus on resilience and recovery • use data to inform practice.
Funders	• be underpinned by equitable funding models, which also focus on shifting investment up-stream to prevention over time • prioritise services/responses that reflect evidence and promote the development of best practice (defined as dynamic, evidence-informed, innovative and open to change) • prioritise services/responses that are culturally competent as well as clinically competent and that reflect whānau ora
System	• use surveillance of health and diseases to develop funding models, service planning and development, alongside broader demographics • be able to relate to other models of care across sectors and at different levels of operation (national, regional, local). • span a range of services, including primary, secondary and tertiary services, those provided by NGOs and those provided in the community • be developed in partnership, with a multidisciplinary and inclusive approach, as all those who will be involved in service delivery need to understand both the model and the principles that underpin it • have clear roles and responsibilities and philosophical differences explored, as these will have an impact on service delivery if not resolved.

[2] The section on Models of Care is adapted from the NZ Commissioning Framework for Mental Health and Addiction https://www.health.govt.nz/publication/commissioning-framework-mental-health-and-addiction-new-zealand-guide

	Depending on the type of response being developed, there may be an overarching model of care reflecting a whole-of-system approach, or it may be more appropriate for the model to be developed to reflect individual service-level expectations.

Demonstrating success

Models of care are important at all phases of the commissioning cycle: they influence opportunities and planning, they need to be monitored and evaluated to check that they are working as expected, and they must be revised and adapted as appropriate to achieve expected outcomes.

Regular monitoring and evaluation of new services also help to identify whether those services are continually developing as expected.

Other factors which contribute to demonstrating success are shown below.

	To demonstrate success, models of care need to:
Whānau	• assess whether services are delivering outcomes for whānau • describe how people with lived experience and whānau were part of the model's design, and what changed because of their contributions • understand changes in context that may have impacted on outcomes
Providers	• Have clear accountability and reporting requirements • tools to support allow data collection throughout the delivery period
Funders	• the information (quantitative and qualitative) that needs to be collected throughout the lifetime of the model • have performance measures which are developed with providers and drive continuous improvement and provide a clear line of sight to track progress in meeting Government and Ministry strategic goals and outcomes • ensure services are run well, monitored, avoid duplication, and are safe, timely and efficient.
System	• the philosophy, evidence and/or assumptions behind the model • the theory of change/ intervention logic used to design the model and the measures • the goals and expected outcomes • outcome measures which can demonstrate improvements for service users, whānau and populations • the implementation plan for the model of care.

4. HOW WE CHANGE

Changes at each stage of the commissioning cycle

This Framework sets out what needs to change at each stage of the commissioning cycle to move to whānau and Māori-led commissioning.

The four broad commissioning stages are determining:

1. Purpose and understanding
2. Designing and planning
3. Sourcing and investing
4. Delivering, monitoring and evaluating.

The Framework also provides guidance on how these changes can be enabled, with key questions, links to guides, tools and resources.

Expectations on how the health entities can support commissioning for pae ora is noted, along with the role locality networks, **Iwi Māori Partnership Boards**, and the broader Social Sector Commissioning work.

The Framework is iterative and will be updated to reflect new understanding and insights as commissioning practice matures. A separate technical appendix sets out the rules and requirements for the commissioning entities, including Ministerial expectations and requirements, relevant legislation, rules for sourcing, funding models and contract features. These will also be updated to reflect any changes.

4.1 Purpose and understanding

Aim: To understand and define the need or opportunity, the outcomes wanted, what's already known to work, and readiness for action.

Key steps

- Determining purpose: identifying the need or opportunity, who is impacted and desired outcomes
- Understanding demand: exploring the size and nature of the problem or opportunity, now and in the future
- What's known to work: from whānau and provider insights, Iwi Māori Provider Boards, locality networks, key stakeholders and research
- Readiness for action: understanding provider capacity and capability to respond.

Determining purpose

To make a real improvement to health and wellbeing outcomes, service users and whānau need to shape system and service purpose. Effective system transformations start by understanding the need and purpose – and outcomes are better when service purpose reflects 'what matters' to service users and whānau.[3]

[3] https://locality.org.uk/about/key-publications/saving-money-by-doing-the-right-thing/

Commented [JO32]: Planners vs searchers: insight from developr economics:
- Planners **raise expectations but take no responsibility for meeting** Searchers accept responsibility for their actions.
- Planners determine what to supply; Searchers find out what is want
- Planners apply global blueprints; Searchers adapt to local condition

William Easterly

Commented [JO33]: For each commissioning stage, the framework sets out the:
- aim
- key steps
- key shifts needed to have whānau and Māori-led commissioning
- what needs to be done, and how – with methods and links to tools and resources
- what is needed from the Ministry of Health and others to enable effective commissioning for pae ora.

Commented [JO34]: Te Tiriti of Waitangi is the starting point of transforming social sector commissioning, and work is underway to change behaviour, practice and systems to improve outcomes for whānau and communities, by moving from:
- short-term, competitive funding approaches to longer-term, collaborative and flexible resourcing.
- rigid input / output contracting to agreements that focus on shared outcomes and that allow flexibility.
- static service design and under-used reporting to generating meaningful insights and adapting services to match people in Government and the sector who transact contracts and compliance to people who have strong collaborative working relationships.

Commented [JO35]: The Māori Health Authority will work with Iwi-Māori Partnership Boards, Māori health providers, iwi, hapū and Māori communities to understand Māori health needs and opportunities for improvement. The MHA will also gain insights from Health NZ, the Public Health Authority, Te Puni Kōkiri and from across the broader social sector.

Commented [JO36]: The 'what matters' to whānau ensures the focus stays on outcomes eg living in a safe secure home. Because government has most control over what it delivers, it is easy for agencies to focus on outputs, eg X number of people placed into state housing. 'What matters to whānau' changes the focus to quality measures of suitability of the house for the whānau, location for work, schools and connection to other whānau, safety, tenure etc.

Understanding demand

Involving service users and whānau when understanding demand (needs and opportunities) improves outcomes. In the past, health needs assessment tended to be a 'desk job' focused on analysing quantitative data; demographics, GP enrolment rates, hospitalisation rates for avoidable illnesses. This often extended to considering the impact of local contexts and social, economic and behavioural factors on health and service accessibility (economic hardship, poor housing, rural or remote areas with no public transport).

The intersection of these factors and sub-groups with higher or different needs would also be considered eg Māori, Pacific, the very young, or very old, members of the rainbow community, those with disabilities.

Engaging the community, and sub-groups within it, is important to include their insights on what is impacting on their health and wellbeing. This would include what's working well with current services, any barrier to access, or gaps, and what needs to improve

This engagement can also help build in a strengths-based targeted approach; what assets, capabilities and aspirations do the people, whānau and community have? Their insights on what is working well and priorities for improvement is also needed.

Engaging with staff, providers, funders and other stakeholders will different perspectives to service users and the community, which can help round out understanding.

Future demand can be estimated based on existing demographics and service use data, as well as broader research on social trends, or socio-economic forecasts.

What's known to work

Evidence from evaluations and broader research needs to be reviewed to have an up-to-date understanding of effective service design, models of care and delivery methods. Added to this the insights from whānau, providers, clinicians and other professionals.

Readiness for action

Understanding the extent to which local providers can meet current and future demand will include considering:

- effectiveness of current services/ models of care
- service coverage across the life course, and intervention spectrum (prevention to treatment, to ongoing care)
- evidence/understanding of better models or ways of working to improve outcomes
- opportunities to collaborate to enable better outcomes, including available mix of disciplines, technical and cultural skills (language, cultural safety)
- provider capacity and capability to innovate as well as delivering current work
- leadership that supports innovation.

The needs assessment can then be used to draw together a view on what's wanted, opportunities, priorities and options. How these get acted on comes at the planning stage, which is also shaped by government strategies and organisational priorities.

Local matters

Deep understanding is needed of local communities and contexts. This includes iwi and mana whenua history and sites of significant meaning, as well as geographic features that shape service access. This can include physical barriers like windy, narrow roads, and well as psychological ones - 'we don't go to services on that side of the bridge'.

Commented [J37]: Consultation works better when there are already trusted and established relationships with different community groups, and where the engagement reflects cultural norms, values and communication preferences (eg te reo, sign).

Commented [JO38]: See key lessons on engaging and designing with the community, including timing, transparency, power sharing, reciprocity and safe guarding.

Commented [JO39]: This includes understanding:
- ability to share health records
- referral patterns and pathways
- examples of integrated service delivery
- collaboration between health and social sector (aged care, disability services, family services, housing etc0

Once the Health and Disability System Reforms have been implemented, local knowledge to inform planning and commissioning will come from Health NZ's locality networks and from the Iwi Māori Partnership Boards.

Figure 3: Levels of engagement by key health and disability sector entities, now and in the future Appendix 3 summarises the roles and responsibilities of the new health entities, as well as opportunities for whānau, communities and social sector entities and Treasury to enable commissioning for pae ora.

Commented [JO40]: Bronwyn - for me this table is about engagement, but also roles and responsibilities in the future in relation to commissioning – mindful much of that is still TBC

Key shifts at the purpose and understanding stage

	From conventional commissioning	To whānau and Māori-led
Whānau	• Assumptions about what matters and what works for whānau • People, whānau and community are seen through a deficit and disease lens, needing to be 'fixed'	• Service users, whanau and community help shape the purpose so systems and services focus on '**what matters**' and '**what works**' for them • A strengths-based approach is taken • Support and services 'work with' people and whānau
Providers	• Providers have little to no input • Low buy-in; 'just more change'.	• Providers are included in shaping service design, and their knowledge and experience is valued and used.
Funders	• Understanding need is predominately 'desk job' based on quantitative data	• Lived experienced provides insight into what is impacting on people and whānau's health and wellbeing, what is working well and what needs to improve in current service provision.
System	• Low inquiry into provider capacity and capability	• Capacity and capability of providers to deliver is a key part of understanding what's needed.

Commented [JO41]: If change happens to you, rather than with you, it can be disempowering and lead to cynicism. The 'co' is key: co-discovery, co-design, co-creation, co-production, to get and keep momentum over time See https://oecd-opsi.org/what-makes-for-a-good-innovation-strategy

Purpose and understanding: what and how

Aim: To understand and define the need or opportunity, the outcomes wanted, what's already known to work, and readiness for action.

	What needs to be done	**How** - methods, tools, resources
Whānau	**Identifying the need or opportunity** What are the needs or opportunities? What is the population of interest: • everyone in a geographic area? • people with a particular: - characteristic (Māori, children, elderly)? - health conditions (long-term conditions)? What is the level of unmet need? What stops whānau engaging and why? What would support their engagement? Does Government have role in meeting this need?	National and local data sets to understand: • the size and demographics of the population of interest and key subgroups • the health issues affecting the population of interest • differences in scale and the type if issues affecting the population • socio-economic context • geographic features that may impact on service access • barriers and enablers of health, wellbeing and equity.
	Determining purpose What are the desired outcomes for service users, potential service users and whānau – '**what matters**' to them?	Engaging service users, potential service users and communities is an essential part of this process. Methods might include: • user experience studies and surveys • journey mapping • observational research; eg site visits • review of complaints • community engagement. The **Iwi Māori Partnership Boards** will have deep local insights, as well as bringing a Te Ao Māori lens to what is needed to improve outcomes and build for the future.
Providers	**Understanding demand** What is local service provision: • type, coverage, mix, and match to need? • enrolment and use patterns: - by key demographics? - by conditions and co-morbidities? - trends and growth.? • effectiveness? Who is missing out? And why? **Readiness for action:** Do existing providers have the capacity and capability to deliver services, innovate and improve? Are there potential providers who could meet needs?	Service mapping • Service location, opening hours, outreach • GP and provider enrolments by demographics, coverage, unmet need • Use: primary, secondary and tertiary service use by sub-groups • Accessibility barriers: cost, location, opening hours • Acceptability: using preferred language, cultural safety, user/whānau experience • Quality: accreditation, reputation and use patterns • Resilience and readiness to innovate

Funders	**What's working, not working, and known to work?** • What investment has been made? • How effective are local services, overall and for the target population? • Are resources being used in the most effective way to get the outcomes that matter? • What is the best available evidence for effective and good value solutions?	• Patterns of investment: purpose, funding amount, contract type, and incentives • Outcomes, overall and for the target group • Outcomes by provider type • Cost benefit/ return on investment analysis • Literature and evidence on effective models of care, commissioning, and continuous improvement.
System	• What is needed to plan for the future, including demand, whānau and community behaviours, expectations and preferences?	• Consolidation of needs analysis, demand projections, existing provider coverage, capacity and capability, readiness and innovation to improve outcomes.

These shifts will be part of what the Māori Health Authority will be leading, but also need to be reflected in the way Health NZ commissions, the role of locality networks and Iwi Māori Partnership Boards in providing local context and priorities, and both the MHA and the Ministry of Health in their system stewardship roles.

From the evidence, what would enable successful commissioning at the purpose and understanding stage?

	Shorter-term	Longer-term
Ministry of Health	Prepare the sector and Ministers for a change in the direction and types of services that will be commissioned (including allocative efficiencies) Exercise leadership and courage as services change to deliver what matters to whānau Prioritise commissioning activities that will achieve improved Māori health and equity. Support effective allocation of resources and identify and address barriers Develop equitable and sustainable funding approaches, which incentivise removing 'waste', building value, innovation and quality improvement	Monitor the extent to which service and system purpose has been shaped by whānau for all commissioning agents in the health and disability system Enable joint work programmes across Māori Health Authority, Health NZ and the Public Health Agency, and across sectors. Support the workforce pipeline to ensure there is capacity, capability and flexibilty
Public Health Agency	Provide population-level data and insights into health inequities, root causes and factors that drive persistent disadvantage Share public health methods that could support system and service design to deliver what matters to whānau	Develop and implement other levers to complement commissioning; for example regulatory levers to shape food environments.
HQSC	Provide insights from the consumer networks	Enable a broader network of service user engagement

Health NZ	HNZ to invest in determining system and service purpose with service users, community and whānau, build a robust surveillance system, review current investments for value, accessibility and effectiveness, health needs analysis, epidemiology, co-production methods and human-centred design, research, evaluation and continuous improvement, alongside collaboration with the IMPBs and the Māori Health Authority to understand what matters to whānau and support their priorities for action.	Build a common data and digital platform to track data and outcomes Use strategic and longer-term advice from IMPBs and the Māori Health Authority on areas for investment.
~~Māori~~ Health Authority	Develop strong, high trust relationships with IMPBs Act on guidance from IMPBs on what matters to whānau at the locality and regional levels	Use advice from IMPBs and locality planners to develop areas for strategic investment and system-level change
Iwi Māori Partnership Boards	Deep connection with, and understanding of, whānau, communities and contexts Resources, design thinking and engagement processes to: • capture 'what matters to whānau' • contextualise what matters to whānau • identify common themes across rohe and motu • influence system and service purpose, so it reflects 'what matters to whānau' identify capability needs to support whānau engage in shaping system and service purpose identify system conditions that make it hard to determine what matters to whānau	Build the kete to capture what matters to whanau, including identifying emerging and unmet needs. Consolidate common themes, and make recommendations on changes needed at a system level Build succession-planning so their rangatahi start to gain experience, insight and leadership
Social sector	Collaboration across sectors and implementing the Social Sector Commissioning work programme	Coordination of engagement with Māori, to reduce consultation fatigue Collective accountability of Māori and equity outcomes.
Te Puni Kōkiri	Share lessons learnt from managing and evolving Whānau Ora from a service, to a provider, to a commissioning agency	Provide guidance on how to shape 'what matters to whānau' in a way that reflects Te Ao Māori framing
Min. Pacific People	Collaborate to support the enacting and embedding of the Te Piringa research recommendations on improving health for pacific people, Ola Manuia and other pacific people-focused strategies	Provide guidance on how to shape 'what matters to pacific people and communities'

4.2 Designing and planning

Aim: To design innovative responses to improve outcomes, using prioritisation criteria and assessment of public value, supported by a plan of action.

Key steps

- **Designing**: what will improve outcomes?
- **Deciding priorities**: and what success will look like
- **Planning**: sequence of actions and approvals needed to turn the idea into reality.

Designing

Innovation is needed, as the current health system and services are not working well for Māori. Commissioning promotes innovation and encourages new services and models of care by challenging whether current services are delivering outcomes that matter, and then developing and testing alternatives.

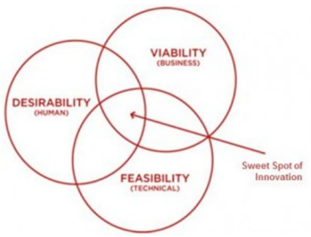
Innovation requires new ways of thinking, designing and delivering services. This can be helped by design thinking, which is a creative process to think about a better future for people. Including people with diverse backgrounds and views helps build richer understanding and insight, including understanding the bigger context.

Key elements of design thinking are to:

- shift the focus from what's always been done, and what works for providers, funders and the system to deeply understand 'what matters' to service users, whānau and community
- ensure 'lived experience' is central to the design process. Personas can also be used to build understanding and empathy; what does it feel like for people using the services now, or navigating a complex health system?
- develop journey maps to understand all the steps and all the providers a person has to navigate/see to get the help that is of value to them
- highlight unmet needs
- create new ways of working together, or new services to improve outcomes and address unmet needs.

Design thinking can be used to include diverse perspectives on a creative journey to understand the 'sweet spot' of:

- what's desirable: it needs to be what whānau want, and fit their lives
- what's feasible: within existing capability (services, sector, technology)
- what's viable: does the solution align with strategic and organisational goals?



Commented [JO42]: For public services, political mandate matters, and for the Māori Health Authority, endorsement from iwi Māori Partnership Boards is also critical to success.

Key lessons when using design approaches

There must be scope for change	Some decision-making power must be devolved to whānau and community, and there must be scope for change as part of the co-design process. If nothing can change, co-design should not be used.
Transparency	Being clear on scope, criteria, thresholds, decision points and non-negotiables (eg regulations, legislation) at the start
Understand 'the now' first	When co-design is used, it can often miss a crucial first step – making sure there is a solid understanding of what is - and what is not - working in the current system or service. This can be done by reviewing case files and observations.
Timing	Ensure there is enough time allocated to the design to allow for appropriate consultation and participation.
Safeguarding	Protections around confidentiality and creating a safe place are a minimum when co-designing with service users, whānau and community members. Additional support may be needed to enable people to contribute, and provision for after care, if it is needed.
Flexibility	Being able to change as understanding of the problem, opportunity and ways of responding grows.
Reciprocity	When service users, whānau and the community share their lives and contribute to improving public services, koha is required. Work is needed to understand what would be valued by the recipients (it's more than recompense, it's recognition of their contribution and their mana).

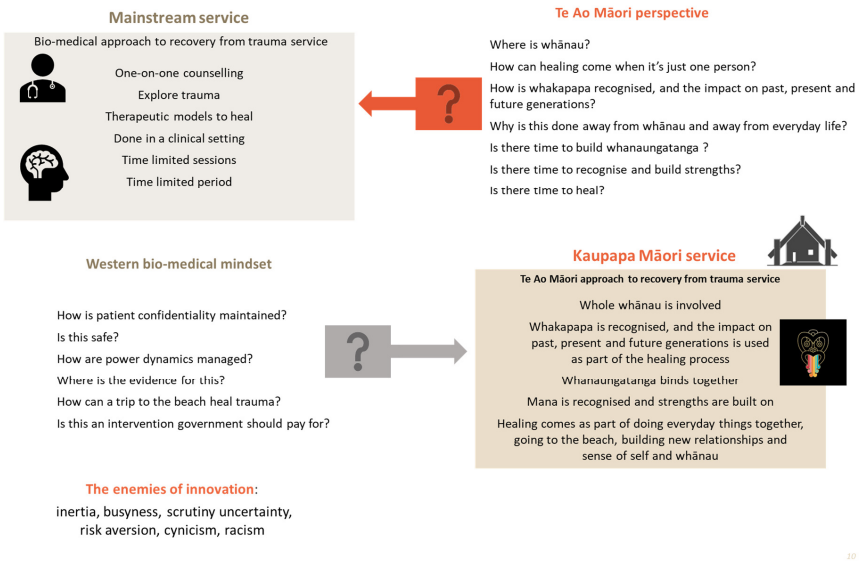
The enemies of innovation: inertia, busyness, scrutiny, uncertainty, risk aversion, cynicism, racism

- Inertia: the biggest enemy of innovation is inertia. It is much harder to try new things, and encounter opposition, uncertainty and potential failure than it is just to keep doing what we have always done.
- Busyness: Innovation takes time, to think differently, explore ideas, set up co-design processes/sessions, find people with different perspectives to join in, then wrangle ideas and work through differences. This is hard in the busyness of service delivery, let alone with a pandemic and sector reform to deal with at the same time
- Scrutiny: there is often pressure to report back on results early on, without sufficient time for implementation, let along improvements in outcomes. The level of scrutiny applied to innovation, and to Māori providers is often also much higher and more public
- Uncertainty: not knowing if the innovation will work can make it hard to get funding or a mandate to go ahead, and the uncertainty of success can make it hard to stay on course when implementation bumps inevitably occur.
- Risk aversion: It is appropriate to have a level of risk aversion when using public funding; how it is invested matters. But the risk of not taking action when current investments consistently fail groups within our community can galvanise action.
- Cynicism: Innovation requires optimism and curiosity.
- Racism: Within the large apparatus of government and the many staff employed, there will be people who are racist. There will also be people who are unaware of the inequitable impacts of policy or service design on some groups, or the impacts of privileging some types of activity or evidence over others. And beyond people, there are systems, structures and processes which create racist outcomes.

Commented [JO43]: Ao Mai Te Rā is a multi-stranded work programme to remove racism in the health and disability system

Figure 2 sets out approaches to trauma services that are part of the mainstream, and an innovative approach being trialled by a Māori provider. (This provider is not funded by the Ministry of Health, as they found our funding application processes too hard).

Figure X: Different world views on trauma services (based on a service outside of health funding)



Deciding priorities

Deciding priorities is a key part of commissioning. It involves making decisions about the allocation of resources between the competing claims of:

- different groups
- different needs and opportunities
- different contexts
- different stages of the life cycle
- different timing (prevention, rehabilitation, treatment)
- different types of investments (services, support, capability building)
- different models of care (western bio-medical, holistic, rongoā)
- different types of providers (public, private, NGO).

All these different elements and perspectives is why priority setting can be hard. What can help work through options is analysing the cost benefit and public value.

Priority setting aims to ensure public value, alongside meeting strategic objectives, for example, reducing inequities, meeting te Tiriti o Waitaingi obligations, fostering Māori-Crown relationships, or redressing wrongs (eg the Royal Commission into Abuse in State Care).

Priority setting is mainly influenced by:

Commented [JO44]: Models of care are evidence-based best practice, that evolve over time as new insight is gained. What can differ is the valuing of different types of evidence. See appendix X for how to develop a model of care that works for Māori.

Commented [JO45]: Public value represents investments that matter to us as nation. Within this, the aim is to also consider value for money, which is about getting the best possible outcome over the whole-of-life of the goods, services or works. Value for money isn't always the cheapest price; it means using resources effectively, economically, and without waste, and taking into account:
- the total costs and benefits of a procurement (total cost of ownership)
- its contribution to the results you are trying to achieve.

- political and strategic priorities
- evidence of what works – and what is considered valid evidence
- assessment of public value
- levels of available resourcing.

Commented [JO46]: The current health system privileges western biomedical approaches, but rongoā Māori and other mātauranga Māori are starting to be enabled.

Priorities can also reflect historical investments and commissioning practices, and what matters to advocacy groups, even when these do not represent public value. Clarity and transparency prioritisation criteria and public value considerations can reduce the impact of these influences.[1]

Commissioners should actively and regularly engage with their local community in priority setting and communicate the outcome and impact of commissioning decisions.

Priority setting in a commissioning environment involves an understanding of the capacity of the market; this will often require a degree of market testing or soundings.

What will success look like?

Agreeing what success will look like (and how it is meaningfully measured) at the designing and planning stage will help ensure that the later, more detailed planning and design aim to deliver these.

How success is measured is worked out when developing performance monitoring, outcomes measures and evaluation approaches. Examples of high level success for key participants are shown in Table X.

Table X: Examples of high level success from commissioning for pae ora outcomes, by participant and time period

	Shorter-term	Longer-term
Whānau	• Earlier access to care • Care is holistic, integrated and meeting needs • Better experience of services	• Health and wellbeing improved for individuals and whānau • Reduction in the intergenerational transfer of avoidable disease (eg type 2 diabetes)
Iwi Māori Partnership Boards	• Iwi Māori Partnership Boards influence prioritisation and investment decisions	• Iwi Māori Partnership Boards have greater levels of devolved power, funding and decision-making
Providers	• Capacity and capability of kaupapa Māori providers increases	• Sustainability and diversity of the kaupapa Māori providers market increases
Funders	• Growing capability to innovate to improve outcomes • Increasing coherence through nationally set priorities • Increased enablement for flexible, adaptive responses to local priorities	• Mature, evidence-based approach to commissioning for outcomes • Devolution of decision-making and funding to allow local innovations (which also have coherence to strategic priorities)
System	• Less waste from delayed/late actions • New insights into what works well • Understanding of what other levers are needed to influence systemic change (eg policy and regulation)	• Improved health, wellbeing and equity • System, services and models of care reflect best evidence • Investment decisions reflect 'what works' or testing to see what works • Improved public value

Planning

The level of planning and detail is shaped by the scale, complexity, level of investment or strategic priority. Plans can help record:

Why	• the case for change • alignment to strategic priorities
Who	• roles and responsibilities of the stakeholders • governance and decision-making arrangements
What	• the design process and what changed as a result of whānau engagement • requirements to proceed to the approvals stage, eg funding request, business case • what's needed to implement (funding, preconditions, skills, lead-in time, communication)
When	• a high level timeframe for approvals and implementation, with key milestones
How	• high-level implementation plan • communication and engagement plan • risks and risk management plan • monitoring approach (delivery, performance, accountability, continuous improvement) • evaluation approach (outcomes, what's working well, what needs to change, future investments).

Commented [JO47]: While funding may not require the level of detail and approval required in NZ Treasury's Better Business Cases, their guidance on the five cases to consider when developing a proposal can help think through what's needed:
- Strategic Case – what is the compelling case for change? What are the benefits?
- Economic Case – What are the options? What is the best option for New Zealand?
- Commercial Case – is the proposed procurement commercially viable? Can the market deliver?
- Financial Case – Is the investment proposal affordable? How will we fund it?
- Management Case – how will the project organise for successful delivery?

Some details in the high level will need to be revisited during the contract development stage; providers will have insights on what is feasible, when, and how performance monitoring can be used to support performance management.

Key shifts at the designing and planning stage

	From conventional commissioning	To whānau and Māori-led
Whānau	Services are not designed around what matters to whānau	Service users and whānau shape system and service purpose so it delivers 'what matters to them'
Providers	Providers' expertise in delivery, and understanding of local contexts and communities is not drawn on	Providers are engaged in the design of new approaches Providers shape meaningful performance measures that explain variance in outcomes and support continuous improvement
Funders	Top-down approach stops innovation Funding follows historical patterns Narrow range of options considered Efficiency and unit cost to deliver services are used as measures of value.	Enable design thinking with diverse inputs, and ensure service users, potential service users and whānau shape the system and service purpose, and the outcomes that matter to them Enable thinking around 'what's possible' Use theories of change and staged approaches to manage uncertainty Costs across the system and public value replaces unit costs analysis.

Commented [JO48]: While service users and whānau are now more commonly involved as the service design stage, this framework aims for co-production throughout all stages; starting at purpose and continuing right through to continuous improvement, evaluation and shaping priorities for future investment stages.

System	Provider failure, or service users not trying hard enough are seen as the main reasons why outcomes have not improved as hoped.	System conditions are recognised as impacting on outcomes, including what evidence is valued, how innovation is enabled, and the impact of systemic and institutional racism on service design.

Designing and planning stage: what and how

Aim: To design innovative responses to improve outcomes, using prioritisation criteria and assessment of public value, supported by a plan of action.

	What needs to be done	**How** - methods, tools, resources
Designing	What will improve outcomes? Understanding of: • what services, models of care or support will deliver outcomes that matter to service users, potential service users and whānau? • how current service models compare to what matters and what works? • what's working, what needs changing?	Methods include: • Case file reviews and observations to assess and quantify service gaps, time from contact to resolution, evidence of escalation and/or repeat contact for unmet need • Lived experience insights, and understanding what matter to whānau from interviews, surveys and design-thinking methods: - Personas - Journey mapping - Service design - Theory of change/ intervention logics to set out how the new approach will improve outcomes. • Providers and other key stakeholders (eg Iwi Māori Partnership Boards, social sector agencies) can be interviewed and surveyed, and they need to be part of the design-thinking work too, noting care in managing power imbalance and safeguarding service users whānau.
	What could deliver these outcomes? • Redesign or integration of existing services? • A new service delivery model? • One-off, or repeat services? • Bundled or separate? What are the expected: • complexities of need? • certainty of outcomes? • ability for service users to change providers, and any costs involved • provider and market capacity and capability to respond? Is a staged approach needed?	Assess resources (budget, people, skills, time) to: • procure the service • deliver the service (value chain analysis) • monitor and support continuous improvement • evaluate • re-commissioning, or de-commission Assessing risks: • Increased demand for services • providers ability to innovate, integrate, meet demand, maintain quality etc • service continuity risks if providers don't deliver Managing risks • Would a staged approach help manage risks; eg agree to a discovery phase with approval gates to proceed?

Commented [JO49]: coming together to improve healthcare https://aci.health.nsw.gov.au/__data/assets/pdf_file/0013/502240/Guide-Build-Codesign-Capability.pdf
Designing for Public Services: a practical guide, created in partnership with IDEO.

Commented [JO50]: Open Government Toolkit on journey mapping – Journey map information, tools and examples from the UK Government.
Government journey mapping tool – Australian government journey mapping tool with a focus on mixed online/offline journeys.
Customer journey mapping – A tool and guide to journey mapping in government, from the UK Government Communications Service.
Customer journey mapping – Private sector focus with good relevance to public sector context.

Commented [JO51]: Service design tools https://servicedesigntools.org/tools
Health Quality and Safety Commission Partners in Care co-design tools https://www.hqsc.govt.nz/our-programmes/partners-in-care/

Commented [JO52]: A 'straw-man' value chain is a chance to build the ideal end-to-end support needed to deliver the outcome wanted. This requires creativity, re-imagining and thinking always about what would matter to whānau. What's desirable will then be refined when working through what's feasible and viable. See Appendix X for a high level value chain template for public services.

Deciding priorities	• What can be done within existing conditions? • What additional resources are needed? • Can they be obtained in the time needed? • What delivers outcomes that matter to whānau and hits the 'sweet spot' for innovation of desirable, feasible and viable?	• Define high level measures of success • Assess: - alignment with strategic priorities - against te Tiriti principles and equity impact - provider capacity, capability and readiness - available funding, amounts, criteria, approval process and timing - cost benefit and return on investment
Planning	A clear and agreed record of what has been agreed, including purpose, what success looks like, governance, approvals and funding process, key deliverables, timeline and risk management.	• Planning templates • Business case templates • Approvals

Commented [JO53]: See the NZ Treasury guide to social cost benefit analysis. https://www.treasury.govt.nz/sites/default/files/2015-07/cba-guide-jul15.pdf Treasury's CBAX tool (required when preparing Budget Bids) can be used to monetise impacts and provide return on investment analysis. https://www.treasury.govt.nz/publications/guide/cbax-spreadsheet-model-0

Commented [JO54]: See NZ Treasury's Better Business Cases (BBC) resource page. Treasury's Better Business Case templates are required for all **significant investment proposals** - defined mainly around risk, level of investment and Cabinet or Ministerial approval. There is also a requirement to use the BBC template for any significant innovation or non-traditional approaches to procurement or alternative financing arrangements, even if funded from agency baselines and balance sheets. See Cabinet Office circular CO (19) 6: Investment Management and Asset Performance in the State Services.

From the evidence, what will enable successful commissioning at the designing and planning stage?

	Shorter-term	Longer-term
Ministry of Health	Monitor the designing and planning processes used and products developed by health and disability entities to ensure whānau voice shaped system and service design	Support investment in workforce development, training and funding to enable innovation alongside maintaining quality and safety Workforce pipeline to ensure collaborative, cross-sector and multi-disciplinary skills are available, as well as the technical and engagement skills needed to commission well. Scholarships to attract Māori into commissioning, co-design and evaluation roles
Public Health Agency	Share public health systems thinking, research and tools that could support system and service design to deliver what matters to whānau	Joint planning and investment to combine public health interventions alongside service design to improve outcomes for Māori and build active protection
HQSC	Share guidance on how to embed quality and safety into service design	Support capacity and capability of kaupapa Māori service providers in delivering quality and safe services, while retaining Te Ao Māori approaches
Health NZ	Collaborate with IMPBs and the Maori Health Authority to identify gaps in services across the levels of intervention (primary, community, secondary, tertiary) and between service provider type (eg private GP and PHOs and public health services and NGOs Development of • Health NZ Plan • workforce strategies • service strategies	Develop integrated care models to reduce gaps and improve transitions between levels of care and provider types (private, public, kaupapa Māori, NGO) Development of: • Health NZ Plan • workforce strategies • service strategies • national service specs framework Locality planning

	Review of the National Service Framework Library Locality planning	
Māori Health Authority	Enable innovation at the locality level, through funding, tools, resources Provide guidance, tools and support to ensure innovations can meet government accountability requirements Build capability in design-thinking using Te Ao Māori framing	Identify capacity and capability constraints in kaupapa Māori providers, and the provider market as a whole Develop and test methods for assessing public value that align with Te Ao Maori framing (building on social cost benefit analysis and social return on investment methods, which include wellbeing measures) with Te Puni Kokiri and Treasury
Iwi Māori Partnership Boards	Enable local engagement and design of services Develop 'Theories of Change' which reflect Te Ao Māori framing of issues and how actions will influence outcomes	Develop and share Te Ao Māori framed Theories of Change, models of care and service designs that reflect what matter to whānau, noting pre-conditions for success. Involve people with different lived experiences and perspectives so their hopes for the future shape the present, and build in succession planning.
Social sector	Identify areas to prototype more integrated approaches to health and social services	Develop integrated models of care for health and social services. Use technology and innovations to solve 'wicked problems'
Te Puni Kōkiri	Monitor funding allocated to Kaupapa Māori providers Develop guidance on what constitutes a Kaupapa Māori provider or service	Develop and test methods for assessing public value that align with Te Ao Maori framing, with Treasury MHA Identify capacity and capacity needs across kaupapa Māori providers Potential accreditation of services according to their capacity, capability to deliver kaupapa Māori services…?
Min. Pacific People	Monitor funding allocated to Pacific providers Develop guidance on what constitutes a Kaupapa Māori provider or service	Develop and test methods for assessing public value that align with Te Ao Maori framing, with Treasury MHA Identify capacity and capacity needs across kaupapa Māori providers Potential accreditation of services according to their capacity, capability to deliver kaupapa Māori services…?
ACC	Develop targeted innovations, in collaboration with different parts of the health system (public health, primary and community, hospital and specialist)	Develop joint work programmes and investment strategies

Treasury	Provide guidance on measuring wellbeing and collective impact.	Review requirements in Budget Bid templates to allow innovative and integrated services to meet evidence standards required to access sustainable (not just prototype) funding Develop and test methods for assessing public value that align with Te Ao Maori framing, with TPK and MHA

Supporting integrated services and support across sectors

When a health care system is aiming to deliver outcomes that endure, the need for service and sector integration increases, as people are complex and require whole-of-person care. Commissioning can help contribute to more integrated support by seeking to understand – at each stage of the commissioning cycle - how people and whānau have experienced services – where services seamless, fragmented, inaccessible or not available?

Commented [JO55]: The Public Sector Act 2020 requires the public service to unify and respond to big challenges like reducing inequities and improving wellbeing. The **Public Finance Act 1989 wellbeing amendment** creates the enabling environment, with:
- a focus on broader wellbeing
- a move away from compliance-based accountability
- appropriations structured to support longer-term, cross-sector investments
- more flexibility to support cross-sector responses to complex issues.

4.3 Sourcing and investing

Aim: To find the right provider to deliver the service or support, using contract requirements to ensure that what is delivered '**works for whānau'** and is a good use of public funds.

Key steps

- **Sourcing**: deciding the right sourcing approach to deliver the service purpose, then undertaking appropriate sourcing for delivery of services
- **Investing**; developing the contract with conditions to enable and incentivise the desired outcomes

Sourcing

When Government entities undertake commissioning, they are bound by the Public Finance Act 1989, procurement rules and principles (accountability, openness, value for money, lawfulness, fairness and integrity). These are set out in the following documents:

- Government Rules of Sourcing and the Principles of Government Procurement[4]
- Office of the Auditor General's Procurement Guidance for Public Entities.[5]

Purpose of procurement rules and principles

[4] https://www.procurement.govt.nz/assets/procurement-property/documents/government-rules-of-sourcing-procurement.pdf

[5] https://oag.parliament.nz/2008/procurement-guide

Consistency	The documents: • set out what is needed for the responsible purchasing of goods, services, and works • establish consistent and predictable processes, making it easier for agencies, providers and suppliers to work with each other.
Contestability	The processes: • ensure open competition, so public funding is not captured through power, influence or bribes • avoid creating default monopolies by limiting competition
Public value	• focus on achieving 'public value' through a mix of: - good quality services - good outcomes - fair price.

Commented [JO56]: Agencies must also be aware of, and comply with relevant law, including the common law of contract, public law and commercial law obligations.

Commented [JO57]: Commissioning and contestability are concerned with identifying best practice in service delivery, gaining insight to support continuous improvement, adopt new innovation and adapt to changing contexts, demand and opportunity.

Commented [JO58]: There is a question around the All of Government Panel, created to allow funders to use a faster commissioning process when choosing a panel provider. Providers are accepted on to the panel when the have been assessed to provide high quality services at a good price. In some categories relevant to commissioning (eg design thinking and evaluation) there are very few providers. The time saving for funders means these AOG panel providers are used again and again. Barriers to entry to the AOG panel for other providers are cost, and the ability to demonstrate a track record of delivery, which the AOG panel interrupts.

Provider markets

Commissioning requires a 'market' of service providers able and willing to bid for contracts and provide services within a commissioning framework.

How are provider markets shaped?

The mix, breadth and depth of provider markets are shaped by an interplay of:

Market drivers	• market drivers which can attract providers to set up, in response to consumer demand, government policy and new technologies • certainty of future demand, based on historic delivery patterns and projected changes in demographics, context, competition and anticipated need
Capacity and capability	• the capacity and capability of existing providers to meet current and future demand, including provision of new services or services in new locations • changes in the availability of better alternative providers, meaning some providers cease to attract funding or service users.
Barriers to entry	• barriers for new providers, including set up costs, meeting service standards, regulatory requirements and uncertainty of demand

Market stewardship

Government sometimes intervenes to ensure there are resilient service systems with well-functioning providers and provider markets, which are essential for effective commissioning. Government can:

Support providers	• sustain existing providers (funding levels and contract periods enable providers to recruit, train and retain skilled staff) • encourage new providers into the market (with guaranteed contract volumes and longer contract periods, and support with set-up costs)
Incentivise	• incentivise collaboration between providers (and removing competitive contracting) • incentivise services to match demand (locations, populations, service types, modes of delivery).
Manage risk	• manage risk by transitioning services in or out of government without due consideration for market depth, user maturity, and service continuity.

Commented [HC[59]]: Not sure we want to create new markets per se – want greater sustainability and size for current providers

Commented [JO60R59]: This is about encouraging new providers into the market – Mental Health team used a different procurement approach which removed the system barriers to entry, and now have new kaupapa Māori service providers

A risk to guard against is replacing local services, which provide good care but lack capacity or expertise to applying for contracts with 'outside' services who have the capacity and expertise but lack the local relationships.

Investing

The New Zealand Government Procurement website[6] contains guides and templates to support procurement practices by public entities.

Procurement is more than spending money. It is the legal and technical process of seeking bids and getting services or goods from an external source, such as a service provider, an NGO or a business. The commissioning agent can describe what they are looking for, and potential suppliers can respond. This usually covers information around quality, experience, price and time. [7]

Government agencies are increasingly adopting co-design practices (to various levels of fidelity). But a lack of maturity across end-to-end processes means that the service user, whānau and community voice can be 'squeezed out' through the mechanics of procurement processes, contracting and accountability requirements.

There is often more scope for innovation within existing legislation and procurement rules, but practices have normalised around narrower interpretations. What can be done now is to ensure procurement advisors and contract managers are part of the journey of supporting innovation in service and system design, as well as providing expertise on how to meet accountability requirements.

> *"Innovation in procurement practice is the most likely path to innovation in service delivery"*[8]

[6] https://www.procurement.govt.nz/procurement/

[7] https://neweconomics.org/2014/06/commissioning-outcomes-co-production

[8] The art of the possible in public procurement, Frank Villeneuve-Smith and Julian Blake (2016).

On-going training and support to embed new practices is also key (and often not done well).

Funding options

Key considerations when developing funding solutions within a commissioning system[9] include:

Who holds the funding	• who in the commissioning system is best placed to hold and control funding, with the ability to make the most informed choice to generate the best outcome, eg government agency (the commissioner), the service provider or the service user
Incentives to collaborate	• how could funding be better structured to encourage cross-agency collaboration e.g. through pooling of funds from multiple agencies [10]
What releases funding	• what process is used to release funding, so it enables the best performance and ensures desired outcomes are achieved. Options include pre-payments, milestone payments, bulk payments and performance bonus payments

Commented [JO61]: In Mana Whaikaha and some parts of Whānau Ora service delivery, service users and whānau have flexible, individualised budgets and exercise choice and control on how these are used.

Commented [JO62]: •**Pooled budgets** combine funding from more than one source to pursue a common objective. This removes siloed funding. Pooled funding can be governed in a number of different ways; by a lead provider, another entity or through 'individualised budgets' allocated directly to service users.
•**Aligned budgets** involve partners assigning a part of their own budgets to support a common shared responsibility; each partner remains responsible and accountable for their funding contributions and controls their own budget

Contract features

Feature	Description
Contract duration	• Contract duration sends signals to the market about the value of the opportunity • Long contract durations do not have to have fixed attributes and can allow for changing in technology, innovation, performance and price.
Renewal terms	• Renewal terms can impact provider behaviour and performance, and need to be sufficiently outcomes-focused to ensure providers perform through to the end of the contract
Volume guarantees	• The more uncertainty, the higher the risk premium (and therefore price) is likely to be. Guaranteed volumes can reduce uncertainty, and risk premiums.
Service quality and minimum standards	• Contracts can support the promotion of service quality and adherence to minimum standards (including statutory requirements) by specifying the service requirements and consequences for success or failure. • The service requirements outlined in a contract need to be supported by a robust monitoring and assurance regime which uses both qualitative and quantitative data to assess quality and compliance.
Service continuity	• Service continuity is a key challenge, particularly for services contracts, particularly for services types that require maintaining customer/provider relationships and in shallow markets. • In the case of shallow markets, commissioners may want to invest in supporting providers to improve performance and sustainability [11]rather

[9] See https://www.saxinstitute.org.au/wp-content/uploads/Commissioning-primary-health-care.pdf

[10] This approach is used in the quota refugee health programme and the joint venture for family violence and sexual violence.

[11] Commissioning agencies needs to plan for both sustainable and equitable funding.

	than implementing any sanctions too early. This could be reflected in areas of pricing and performance.
Risk allocation	• Risk allocation refers to the provisions in a service contract that determine who is responsible for assuming the risk of certain events occurring (or failing to occur). • There are three main considerations in respect of risk allocation, which also impacts price. These are operational, financial and reputational. • The level of risk assumed by a service provider can impact on the proposed price and/or performance of services and is a fundamental consideration.
Failure regime	• The consequences of not meeting performance thresholds and other forms of service failure (eg failure to meet statutory or minimum standards) need to be clearly articulated in a service contract. These can be construed in terms of "one off" events (eg. a major health and safety breach) or more gradual performance failures. • **These risks can also be managed, mitigated and avoided through a partnership approach to continuous quality improvement and solving contract and service delivery issues/problems.**

Contract management

Measures	The performance management regime for providers, usually expressed in a contract. Tailor measures to purpose and level of detail needed to assess results and manage risk: • Outcome measures that are meaningful to whānau and reflect purpose • Lead and lag indicators • Performance measures which: - provide a clear line of sight to strategic goals - explain variation in outcomes and generate insights to support continuous improvement • Social cost benefit analysis • System costs and public value measures
Reporting	Co-design reporting frameworks and templates with providers that: • only collects what is useful, and uses existing data wherever possible • is commensurate with the level of investment and risk • provide performance and outcome data • meets requirement that allow results to be compared across time, groups and locations • links outcomes to cost of delivery • meets ethical and privacy requirements, including data sovereignty.

Key shifts at the sourcing and investing stage

	From conventional commissioning	To whānau and Māori-led
Whānau	• Fewer options of kaupapa Māori services	• Increased options for kaupapa Māori services
Providers	• Barriers to entry for new kaupapa Māori service providers • Commissioning may negatively disrupt local provider systems if processes exclude good providers from tendering/applying • Contracts do not cover full cost of service delivery • Contracts are highly specified • Performance measures do not provide useful insights; just track outputs • High compliance costs from multiple small contracts, with different reporting requirements • Low capacity for innovation • Low trust on support, or future contracts, if new ideas don't work	• Support for new kaupapa Māori providers to establish (grant funding, capacity building, mentoring) • Streamlined reporting • Co-designed reporting, so providers can 'tell their story, and the information is useful to them and funders • Use of existing data • Requirements to share data • Reduced manual input
Funders	• Low use of theories of change at the design stage makes it harder to translate key requirements into the contract • Limited research on what contractual levers support: - provider performance - better outcomes for whānau • Data does not provide insights on variations • Data does not support continuous improvement • Lack of understanding of the end-to-end commissioning process • Limited workforce with the range of technical and engagement skills to commission well	• Monitoring reports are actively reviewed and used to support continuous improvement; for service design, delivery and commissioning processes. • Workforce capability, training • Support a learning culture, and front-foot criticism when new ideas fail •
System	• No active market shaping for kaupapa Māori providers • Limited pool of kaupapa Māori evaluators	• Active market shaping of kaupapa Māori providers, in partnership with the social sector • Support a learning culture with leadership that can respond to criticism when new ideas fail

Sourcing and investing stage: what and how

Aim: To find the right provider to deliver the service or support, using contract requirements to ensure that what is delivered '**works for whānau'** and is a good use of public funds.

	From conventional commissioning	To whānau and Māori-led
Whānau	Fewer options of kaupapa Māori services	Increased options for kaupapa Māori services
Providers	Barriers to entry for new kaupapa Māori service providers Commissioning may negatively disrupt local provider systems if processes exclude good providers from tendering/applying Contracts do not cover full cost of service delivery Contracts are highly specified Performance measures do not provide useful insights; just track outputs High compliance costs from multiple small contracts, with different reporting requirements Low capacity for innovation • Low trust on support, or future contracts, if new ideas don't work	Support for new kaupapa Māori providers to establish (grant funding, capacity building, mentoring) Streamlined reporting Co-designed reporting, so providers can 'tell their story, and the information is useful to them and funders Use of existing data Requirements to share data Reduced manual input •
Funders	Low use of theories of change at the design stage makes it harder to translate key requirements into the contract Limited research on what contractual levers support: provider performance better outcomes for whānau Data does not provide insights on variations Data does not support continuous improvement Lack of understanding of the end-to-end commissioning process Limited workforce with the range of technical and engagement skills to commission well	Monitoring reports are actively reviewed and used to support continuous improvement; for service design, delivery and commissioning processes. Workforce capability, training Support a learning culture, and front-foot criticism when new ideas fail •
System	Is there a level playing field between private and public providers?	

	What short, medium and long-term strategies are needed to develop the kaupapa Māori provider market?	

From the evidence, what will enable successful commissioning at the sourcing and investing stage?

	Shorter-term	Longer-term
Ministry of Health	Monitor contracts with kaupapa Māori providers (purpose, provider, location, amount, duration) Manage risks if decommissioning kaupapa Māori contracts and continuity planning	Monitor outcomes from whānau-shaped, Māori-led commissioning Accessible and accurate provider performance data, including service user outcomes and satisfaction Monitor the devolution of decision-making power and funding to Iwi Māori Provider Boards and locality networks
Public Health Agency	Identification of issues that require public health levers to influence	Coordinated investments and assessments to test the benefits of combining public health interventions alongside service innovation
HQSC	Guidance on quality and safety standards	Review of quality and safety of kaupapa Māori service providers and areas for support
Health NZ	Co-commissioning with the Māori Health Authority Review of investments by provider type, service type and location Reviewing and addressing barriers to accessing funding for kaupapa Māori providers Develop an investment strategy to increase funding to prevention over time	With the Māori Health Authority develop an investment strategy to build the capacity and capability of kaupapa Māori service providers, and the kaupapa Maori provider market overall (with input from MSD/ Social Sector Commissioning) Increase contracts and funding for kaupapa Māori providers Increasingly move funding to prevention Monitor all providers to ensure they are contributing to improving Māori health and equity.
Māori Health Authority	Examples of types of innovation already possible within existing sourcing rules and procurement principles Co-commissioning with Health NZ Review of Health NZ's investment into kaupapa Māori services and service providers Tools to reduce compliance costs for providers	Monitor the capacity, capability, depth and breadth of the kaupapa Māori provider market, recommend an investment strategy Monitor funding and funding conditions received by kaupapa Māori providers by funding source; do the patterns demonstrate increasing trust?
Iwi Māori Partnership Boards	Feedback on barriers to access funding experienced by kaupapa Māori providers Capacity and capability pressures for these providers	Insights on system enablers and constraints to access prototype and sustainable funding for kaupapa Māori providers Involve rangatahi in prioritisation; it's their future being shaped

Social sector	Sharing insights on sourcing and investing best practice to build diverse provider markets and sustainable kaupapa Māori providers Tools to support contract design and reporting that reduces compliance costs	Accessible and accurate provider performance data, including service user outcomes and satisfaction Lead capability building and market shaping of kaupapa Māori providers, in collaboration with the Ministry of Health, Health HQSC and Iwi Maori Partnership Boards
Te Puni Kōkiri	Review investments across the health and social sectors in kaupapa Māori services Advise on how to protect data sovereignty alongside build and evidence-base of what works	Support whānau-level measures of success
Treasury	Clarity on the requirement to use Better Business Case templates for innovation outside of usual procurement practices Review MBIE sourcing rules and AOG panel from an equity lens; do they create unintended barriers to entry for some providers (focus on services needed in whānau-led commissioning, eg design-thinking, monitoring and evaluation)?	Respond to systemic barriers faced by kaupapa Māori providers to access funding Support Budget Bids to develop emerging kaupapa Māori Providers and build the kaupapa Māori provider market Monitor the shift of funding across the health and social sectors up-stream to prevention

4.4 Delivery, monitoring and evaluation

Aim: To implement the service or intervention, monitor how it delivers against intended operation and budget, and evaluation of outcomes - what worked well and lessons learnt - and implement improvements (or decommission).

Key steps

- **Delivery:** ensuring what is needed to deliver the services are well are in place and services are delivered as intended
- **Monitoring**: tracking delivery against intent; what was delivered, when, to whom, how often, how long and at what cost, reasons for variations, issues, risks and risk management
- **Evaluation**: did the service or intervention generate the desired outcomes, reasons why (or why not), what worked well, and what needs improvement?

Delivery

Providers are responsible for ensuring the pre-conditions for success are in place, and then delivering the services to the standard, quality, length, volume or other criteria in service level agreements developed as part of the contract specification.

Monitoring

Monitoring is the systematic assessment to understand whether the commissioned response is on track to deliver the expected results. Monitoring often tracks:

- service delivery against agreed standards, volumes and other agreed criteria
- reasons for service use
- service use by key demographics (age, gender, ethnicity) – and who is missing out

- results by service user characteristic (demographics, needs, conditions)
- referral pathways
- actual against planned expenditure
- service gaps, overlaps, duplication and future opportunities
- issues, risks and risk mitigations

The frequency and focus of monitoring is determined by what the service is intending to achieve, and the level of:

- risk from late delivery or poor quality services
- safeguarding needed for the target group (this may be a mandatory through a regulatory framework or a legislative requirement or reflect good practice).
- investment and innovation
- political interest and public scrutiny.

The greater the level of risk, investment, innovation or interest, the robust the monitoring needs to be.

This information can be time consuming to collect, and efforts are needed to ensure that:

- reporting requirements are commensurate with risk and investment
- reporting uses data that is already being collected wherever possible
- where new data is needed, the amount of new data is kept to a minimum
- data helps provides insight into:
  - outcome variation
  - areas that need to be improved.

Commented [JO63]: Analysis might show that a service is more effective for some groups, or when delivered in different ways, eg home based care.

Ongoing monitoring requires regular discussions between contract managers and providers about how the services or model of care is working, what results are being achieved, lessons learnt and areas for improvement. The impact of contract incentives to innovate and integrate can also be reviewed. **This requires a relationship of trust, and working together as learning partners.**

Monitoring may highlight where changes to the service design or delivery may need to be agreed, for example to respond to unanticipated demand, unmet need or changed context.

Evaluating

Evaluation uses a mix of methods and perspectives to:

- assess what outcomes resulted from the service or investment
- understand why these outcomes occurred
- identify any unintended outcomes (positive and negative)
- understand what worked well, and what could be improved
- prioritise what improvements could be made.

Methods

The Theory of Change developed at the design phase will help determine what methods are need to assess outcomes and understand why they occurred.

As noted, the Theory of Change will be shaped using Te Ao Māori framing, as part of the overall aim of learning what matter to whānau and works for whānau.

Assessing wellbeing, and changes that can be attributed to a service or intervention can be technically hard. Often a range of wider - and more powerful factors - than the service or intervention can also influence wellbeing; like having enough money to live, having a safe, warm home.

Assessing contribution to outcomes, rather than attribution, is often more realistic and meaningful. A way of doing this is to ask service users and whānau about how the service or intervention has helped them, and how it has contributed to their health and wellbeing. Having intermediary steps on the journey helps to show progress towards longer-term outcomes.

This information will also help refine understanding of what matters to whānau, and what works for them, and may lead to a revision of the original Theory of Change.

Robust, tested Theories of Change are critical to explaining how and why a service works, and also supporting replication of successful approaches, as they set out the key ingredients for success.

Revising and adapting

By monitoring and evaluating the services against expected outcomes and the key steps in the Theory of Change, insights will be gained on the effectiveness for different groups, and what needs to be improved.

This leads into repeating the first stage in the commissioning cycle, understanding and purpose. There may be opportunities to adapt the service so it better meets needs, start the commissioning cycle again if a more substantial re-design is needed, or make a recommendation to stop funding – decommission

Decommissioning

Decommissioning is the process of planning and managing a reduction in service delivery or stopping a service due to a failure to deliver outcomes, changed priorities or context.

Before a decision is made to reduce or stop a service needs, understanding is needed on:

- the immediate and longer-term 'whole-life' impact on service users, whānau and wider community
- the availability and capacity for other providers to absorb demand
- how key stakeholder relationships and the provider market will be affected (the risks of decommissioning, and the availability of alternatives)
- what is needed to comply with legal, financial and statutory requirements
- equity of health outcomes if a service gap is created.

Decommissioning can be hard, and sometimes decisions are reversed due to political or stakeholder advocacy, even when the service is no longer meeting demand or providing public value.

Decommissioning can be supported by:[12]

- having a clear rationale and seeking consensus on the reasons why change is needed
- focusing on public value (the need to direct funding to what produces outcomes)
- good governance and clear decision making processes

[12] UK National Audit Office guidance on decommissioning.

- early signalling to all stakeholders and good communication throughout
- robust risk management.

Reducing compliance costs and building data quality for insights and improvement

Issues raised by Māori primary and community providers as part of application process for funding 97 out of estimated 280 potential providers		
	What providers find challenging	What they want
Delivery	• Ineffective systems to manage client and staff information • Often using excel to record client details, and basic information about them • Reliance on paper-based notes • When data systems are available, they often - lack storage space - require lots of manual entry • Limited capacity for clients to contact them "Our biggest complaint from our community is that they can't get through on our phone lines"	• Effective, future-proofed practice management database • 0800 numbers to increase capacity • Ability to remotely connect to service users and their whānau, and other staff using ZOOM/ Teams video, and work from home
Monitoring & evaluation	• Existing data systems have: - limited reporting functions - no graphics to support analysis and insights • The ability to scale up is "*limited by poor understanding of outcomes and measurement*" • Current systems are not cost-effective, are hugely time consuming and require significant resource • The Client-Led Integrated Care CLIC system we are required to use has limitations with data capture and reporting	• Practice management database that: - allows whānau to directly access their information, and add to it - tracks outcomes at the client, whānau and programme levels - tracks budget expenditure against costs - graphics and reporting functions to produce better insights Increased capacity and capability in : • developing meaningful performance measures, and outcome measures • analysing, reporting and using insights to support continuous improvement.

Key shifts at the delivery, monitoring and evaluation stage

	From conventional commissioning	To whānau and Māori-led
Whānau	System and services make assumptions about what matters and what works for whānau	What matters to whānau shapes service design and delivery Outcome measures are meaningful to whānau
Providers	Monitoring and reporting requirements are a often a burden, and the data does not add insights[13] Monitoring can be seen as reflecting 'surveillance and suspicion' from the funder, rather than focusing on learning and improvement.[14]	Monitoring uses existing data wherever possible Providers shape performance measures, so data creates insight on what needs to be improved Monitoring is more about learning together, and supporting improvement There is trust; when things don't work as hoped, the insights are valued and propel improvements
Funders	Monitoring and evaluation focus on outputs, as these are easier to assess and attribute Services are commissioned with a lack of a clear purpose, or understanding of how the service will lead to outcomes Outcome measures don't measure change from the service (what's expected is more than the service could reasonably influence or measured before change could occur).	Outcomes matter, and whānau views on what worked and why helps shape service improvement A learning culture means qualitative data on why things worked, or didn't, is valued as it helps shape what's needed to improve The mix of influences on outcomes is understood A maturity model helps mark out the steps to a mature system and track progress and inform areas for investment.
System	Monitoring and evaluation don't assess value for money; they focus on cost of delivery only Lack of public value assessment means it is hard to know which service to re-invest in.	Te Ao Māori framing shapes new ways of assessing public value There is increasing sophistication in investment decisions to improve outcomes for Māori, based on a growing body of evidence of what works, for whom, under what circumstances.

[13] Ministry of Social Development. 2020.
[14] Ministry of Social Development. 2020.

Delivery, monitoring and evaluation stage: what and how

Aim: To implement the service, monitor how it delivers against intended operation and budget, and evaluation of outcomes, what worked well and lessons learnt.

	What needs to be done	**How** - methods, tools, resources
Whānau	Whānau shape system and service design Whānau develop measures of success that are: • meaningful to them • will support improvements at the service delivery, and the system level Whānau views on priorities for action are sought and acted on Whānau shape strengths-based measures and whānau level measures	There are changes in system and service design and delivery that reflect what matters, and what is meaningful to whānau, and these are documented in the design purpose and design stage Whānau engagement and influence at every stage of the commissioning process is enabled, recognised and documented Whānau provide insights which improve engagement and co-production approaches Whānau feedback is acted on, and is used to improve system and service design and delivery The ability to report from a capability and strengths-based perspective increases Whānau-level measures of success are developed.
Providers	Performance monitoring that is co-designed with providers, and adds insight on why outcome vary, and support continuous improvement	Providers are encouraged to report back to their communities; funders start to use this as the main form of accountability
Funders	Performance monitoring is used to improve services Funders co-design reporting templates with providers, collecting the minimum data needed and using existing data wherever possible Funders analyse data for providers, and develop insights for providers that help improve service delivery and understanding 'what works' and for whom. Evaluations take a critical friend' approach, to focus on improving service design and delivery Kaupapa Māori evaluators are used wherever possible, and outcome frameworks are co-designed and reflect Te Ao Māori framing	Funders co-design reporting tools with providers, eg powerpoint format to aid story-telling, photos and videos, excel spreadsheets which produce graphs and trend data for providers without data management systems A3 posters of service purpose and contract details help other funders know what other contracts the provider has Extracts from existing data system where possible, with funders using this data to prepare reports, to lift this work off providers When assessing cost-effectiveness of services, the commissioning overheads need to be included, these are estimated to be around 15% of total contract price. [15]

[15] Based on estimates from the UK. See https://www.saxinstitute.org.au/wpcontent/uploads/Commissioning-primary-health-care.pdf

	Methods for assessing system costs and public value are used wherever possible and meaningful	For large scale programmes, establish the counterfactual through comparisons of matched groups, people in similar areas or previous periods who did not receive the service. Depending on the level or duration of the intervention, and the numbers seen, comparisons in outcomes could show differences caused by the service.
System	System costs and public value become the main way of measuring investments	Contract and provider data infrastructure is built to allow system costs and public value assessments Te Ao Māori framing of public value is developed and tested

From the evidence, what will enable successful commissioning at the delivery, monitoring and evaluation stage?

	Shorter-term	Longer-term
Ministry of Health	Build measures and performance monitoring of the reform's intent, including evidence of: service integration Budget Bids which prioritise prevention	Monitor and report on: increasing transfer of health funding to prevention, including public and population health Māori health and wellbeing and health inequity improved service integration
Public Health Agency	Prioritised work programme focusing on system-level levers to improve public health	Increasing use of system levers (eg regulation) to create healthy environments as part of embedding active protection Te Tiriti o Waitangi principle
HQSC	Guidance on how to improve service design and delivery from a health and safety perspective	Build understanding of health and safety within a Te Ao Māori framework, to help build provider and funder capability
Health NZ	Work with MHA to use Te Ao Māori framing in evaluations and public value assessment Review BAU services, to identify and remove waste in the system Support innovation	Monitor and report on: • progress in shifting funding to prevention • Māori health and wellbeing • reduced health inequity • improved service integration • improved cross-sector collaboration
Māori Health Authority	Monitor the quality and robustness of outcome measures, frameworks and performance monitoring	Support capability building in monitoring and evaluation Identify where other levers are needed to support commissioning (policy, regulation)

Iwi Māori Partnership Boards	Support performance management, monitoring, evaluation and continuous improvement design Provide insight and context to reports Provide guidance on when decommissioning is needed and how to manage this to minimise service continuity, impact on people, providers and provider markets	Identify and prioritise areas for capability building in performance monitoring, evaluation, continuous improvement and decommissioning Provide insight on kaupapa Māori provider markets, and areas for investment and capability building Signal changes in context and emerging issues and opportunities
Social sector	The Social Sector Commissioning work programme develops an investment strategy for social sector NGOs, kaupapa Māori providers and other community providers, to build the data and digital infrastructure to reduce compliance costs and improve data quality	The Social Sector Commissioning work programme manages the implementation of the social sector provider capability build Review the impact of commissioning across health and social sector provider markets, and guidance on how not to disrupt effective local services and networks
Te Puni Kōkiri	Te Puni Kōkiri develop a workforce investment strategy with the Māori Health Authority, IMPBs and Social Sector commissioning to build the workforce needed to bring Te Ao Māori framing to co-design, economic analysis, sourcing and investing, evaluation and change management	Scholarships, mentoring and internships are used to build the Te Ao Māori commissioning workforce, with a focus on attracting people with lived experience and understanding of trauma informed support
Min. Pacific People	Ministry of Pacific People develop a workforce investment strategy with the Māori Health Authority, IMPBs and Social Sector commissioning to build the workforce needed to bring a range of pacific framing to co-design, economic analysis, sourcing and investing, evaluation and change management	Scholarships, mentoring and internships are used to build the Pacific commissioning workforce, with a focus on attracting people with lived experience and understanding of trauma informed support
ACC	Support insights on pathways to effective prevention, treatment and rehabilitation Support the development of datasets that help connect outcomes to providers and contracts across the health and social sectors	Contribute to insights on what works (for different communities, contexts and types of preventable injury and harm) Support investment strategies to meet current and projected demand.
Treasury	Te Ao Māori framing of public value is developed and tested Develop and report on the 'cost of late action' as a way of measuring system performance (amount of funding	Budget is released to support investment in the contract and provider data infrastructure to allow system costs and public value assessments across the health and disability sectors

	directed to avoidable services, eg childhood obesity, Oranga Tamariki, youth justice)	Budget is released to build the commissioning workforce The Budget Bid processes supports an increasing shift across the system to prevention.

5. IMPLEMENTING THE FRAMEWORK

The Commissioning for Pae Ora system framework can be used by planners and funders, and links to co-design resources have been included to support engagement with service users, whānau and wider stakeholders.

Implementing the framework will be very similar to what some planners and funders already do; others may find it requires a different way of working. 'Pro-tips' from the Māori Health Directorate's Service Improvement Team and other commissioners across parts and levels of the health and disability system will be included, and videos will be developed to spark ideas and inspiration.

The Commissioning Framework identifies system conditions and enablers needed to move to a whānau-shaped, Māori-led approach to commissioning for Pae Ora.

Successful implementation requires results to be clearly defined, agreed and measured. It will take time to develop measures that capture the benefits of the new approach.

Expected outcomes need to be clearly defined and actual outcomes measured at the national, regional, local and service levels. While there are existing measures that can be used, new measures will need to be developed and tested.

Development of the workforce is also key to implementing the Commissioning Framework successfully. The framework provides a basis for developing the workforce so that those responsible for the whole commissioning cycle are equipped with the right skills and knowledge to enable the development of integrated and innovative approaches.

Those responsible for commissioning will need the right skills and expertise to implement this framework. They will be the drivers of the approach, but all stakeholders need to understand where it is going and what this will mean for them.

Access to resources, training and support will also be important for providers and consumers and their families and whānau, who will play an active role at all stages of commissioning as part of implementing the framework.

Summary of what's needed to do good commissioning

	What's needed	How/ what's needed
Whānau	Understand what matters to whānau and the community is the starting point for commissioning Understand the needs and strengths of the community	Contextual data: demographics, social, economic indicators Health and wellbeing data, overall and for specific groups Service mix, coverage and uptake Community assets and infrastructure Engagement and co-design Iwi Maori, mana whenua Current/potential service users Stakeholder and provider views
Providers	Establish good relationships with providers ahead of starting commissioning processes Look wider than the health and disability sector; include social sector providers and mainstream services (eg education, housing) Understand the provider market; quality, accessibility, mix, breadth, capacity and capability	Whanaungatanga Time Active relationship management Cross-sector collaboration Clear roles, decision-making and reporting processes Analysis of provider markets
Funders	How well do current services and models of care improve health and wellbeing, and reduce inequities Are there better models of care/ services/ investments Do existing providers have the capacity and capability to deliver new ways of working now What additional resources (funding, training, capability building, workforce) is needed to deliver new services/ models of care/ investments Ensure procurement processes are transparent and fair Ensure the procurement process supports the best outcome and public value	Identifying advances in services/ models of care/ investments to improve outcomes Change processes to support existing providers adopt new approaches Provider capability building Identifying and removing barriers to entry for new providers Enable collaboration and consortia building Start from a position of high trust Devolve funding Develop performance measures that assess fidelity to commissioning principles (high trust, devolved power)
System	Lift the focus from unit cost to system cost Take a system approach to assessing public value Aim for broader, enduring outcomes	Have provider and contract management infrastructure that can track funding and outcomes Track system performance; cost of late action measures (ASH, childhood obesity, youth justice, Oranga Tamariki contact) Shift of investment to prevention Assess allocative efficiency

		Build the ability to track contribution to broader outcomes (fidelity to evidence-based programme logics Develop strengths-based measures (move away from disease and deficit) Track drivers of system transformation – including key enablers Anti-racism. Workforce skills and diversity

Skills needed to commission well

Commissioning requires much more engagement and communication than a standard procurement process. Commissioning agencies need resources, skilled staff and timeframes that enable collaboration, innovation, continuous improvement, prioritisation, and the leadership to stop services when they are no longer needed or effective.

	Action	Skills
What matters	• deeply understand local contexts and communities • engage to understand 'what matters' to actual and potential service users, whānau and the wider community, and iwi Maori partnership boards	Community engagement Te Reo, Tikanga, Te Ao Māori
What's needed	• understand current service design and delivery, and how a service system is enabled, funded and implemented to deliver 'what matters' • review how well current services deliver on 'what matters', and 'what works' based on existing evidence	
What's possible	• ensure that new services are co-designed with actual and potential service users, whānau, service providers and key stakeholders, including iwi Maori partnership boards • ensure adequate resources (time, funding, and people) are allocated to deliver the outcomes	
What's priority?	• Understanding trade-offs	
What's being delivered	• work with service users, whānau and community to develop outcome measure that capture 'what matters' to them • work with providers to develop performance measures that will drive service improvement • build and actively implement continuous improvement processes.	
What next?	• what's not working, or no longer needed.	

What's needed to set at the national/regional and local levels to succeed

		National/regional levels	Localities
Whānau	Designing	• Developing guides and tools to support whānau co-design system and service purpose, and design	• Service users, potential service users, whānau and community engage in determining service purpose and outcomes that matter to them • **Iwi Mtori Provider Boards** are resourced to enable strong relationships and deep insights into local needs, opportunities, aspirations, and expectations
	Delivering	• Whānau voice helps shapes services and support	• Service users, potential service users, whānau and **Iwi Mtori Provider Board** feedback is part of continuous improvement process
	Measuring	• Service users and whānau feedback is part of consumer monitoring and quality commissions (eg Health Quality Safety Council, HQSC)	• Service users and whānau feedback as part service evaluation
Provider	Designing	• Help develop service design tools and processes	• Engage and involve providers and professionals in service design
	Delivering	• Provide insight on system-level issues from a provider perspective eg workforce pipeline, funding processes etc • Identify what's needed to build provider capacity and capability	• Guide implementation timing and preconditions for success.
	Measuring	• Shape performance measures that help drive continuous improvement	• Providers shape performance measures to ensure they generate insights that can support continuous improvement.
Funder	Designing	• Develop guides and tools to support whānau co-design of services • Funding approvals require demonstration of how whānau shaped service design	• Service users, potential service users, whānau and community, providers, and key stakeholders co-design services • **Iwi Mtori Provider Boards** provide deep insights and priorities for action.
	Delivering	• Choice protected in contracts or regulation	• Integrated delivery supported by co-located teams and shared geographic boundaries • Time to engage with whānau, providers and professionals to create contracts that enable outcomes and support continuous improvement • Have, or develop, management, technical and financial capability - and stability - of staff to implement commissioning

	Measuring	• Service users and whānau feedback as part of consumer monitoring and quality commissions (HQSC) • Focus on accountability of providers for both cost and quality, including: - outcomes for service users/whānau • reduced inappropriate care (not prevented when possible, not of value to service user/whānau)	• Good information on pattern of service use, quality, and cost of services • Good data systems to monitor performance and outcomes at local levels.
System	Designing	• Clear legal frameworks for: - joint commissioning - pooling budgets - flexible use of budgets • Capitation and incentives that align with commissioning aims	• Clear roles and responsibilities • Enabling governance structures
	Delivering	• Address requirements that prevents cooperation between providers • Assess barriers to: - entry for potential kaupapa Māori providers - to funding/tendering for kaupapa, eg does current way the All of Government Panel (AOG) operates enable increased kaupapa Māori services?	• Strategic approaches to service integration and collaboration across health and social sector agencies
	Measuring	• Common performance measures that drive continuous improvement at the system and the provider level • Common outcome measures that are strengths-based (a capability approach is more enabling, and historic deficit reporting has also had a stigmatising impact on some groups).	• Using common performance and outcome measures

What can undermine commissioning effectiveness?

Commissioning effectiveness can be undermined by:

	Impediments to effective commissioning
Whānau	• challenges in engaging with whānau across all stages of the commissioning process (not just service design), and in keeping engagement over time
Providers	• a lack of potential providers with capacity and capability to deliver quality services • difficulties accessing data held by different entities, and across public and private entities (eg by general practices and primary health organisations)
Funders	• limited understanding, where commissioning is seen as contracting services to third party providers, instead of a comprehensive process of ensuring the best mix of services to achieve outcomes that matter and deliver public value • low workforce capacity and capability in the technical and engagement skills needed across the stages of commissioning
System	• a shortage of data to define needs and measure performance and outcomes • a lack of agreement about priorities and measures • the variety of funding mechanisms and the reliance on fee-for-service for primary health care makes it difficult to have a coherent approach to commissioning.

When these impediments exist unchecked, there is a risk of inappropriate services and poor outcomes, including increasing inequities.

Competitive commissioning processes can be used to generate innovation and efficiency in service delivery, as new approaches are developed. But competition can also result in providers agreeing to contract conditions that put service quality and viability under strain.

Commented [JO64]: For example, if costs of delivery are higher than contract amount, more contracts may be needed operate, increasing work and compliance activity. Staff may also leave for higher pay, more secure roles.

Even when non-competitive approaches are used, commissioning can cut across the relationships needed for effective service delivery; for example:

- good local services can be excluded from contracts because they lack the capacity to tender effectively
- commissioners may choose to manage fewer contracts with a smaller number of organisations where they have a track-record of working well together.[16]

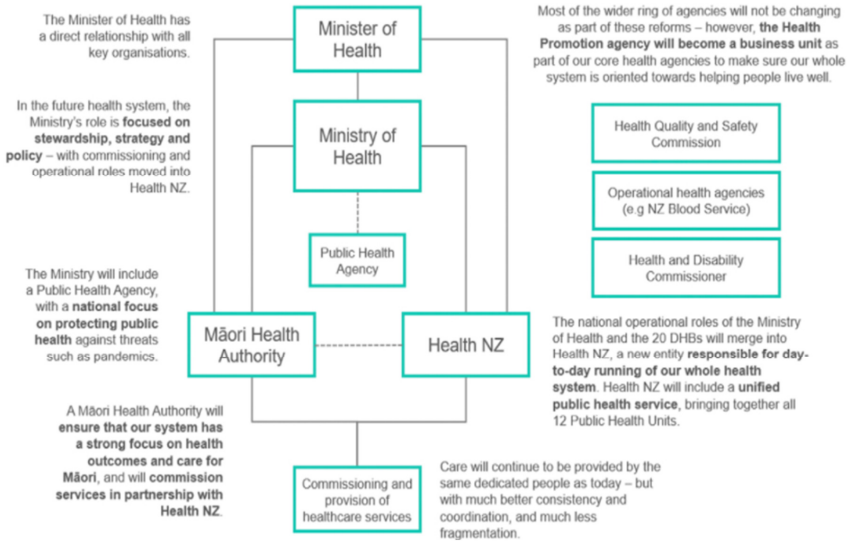
[16] https://www.saxinstitute.org.au/wp-content/uploads/Commissioning-primary-health-care.pdf

APPENDICES

Appendix 1: Health and Disability System Reforms

As the Health and Disability System Reform's recommendations are implemented, the commissioning environment will change. Some of this relate to structural changes to separate and streamline stewardship and delivery functions, through the creation of Health NZ to replace 20 District Health Boards, and the creation of a new Māori Health Authority, and a Public Health Agency. The new structure is shown in Figure X.[17]

Figure X: New Health entities and roles



As well as these structural changes, the reforms seek to:

- build high-trust, collaborative and enabling commissioning
- update legislation to reflect recent interpretations of te Tiriti o Waitangi.
- expand Māori policy advice, population data and insights to better measure and respond to inequities
- build kaupapa Māori providers and services
- move from addressing equity within the system to changing how the system works to improve equity
- move from short/medium term programmes to longer-term collaboration with the social sector.

[17] Figure from *Our health and disability system: Building a stronger health and disability system that delivers for all New Zealanders (White Paper)*, April 2021.

The Māori Health Authority will have statutory obligations to:

Māori Health Authority roles

Engage	• engage with whānau, hapū, iwi and hapori Māori, and key hauora Māori stakeholders
Report	• report back to the above groups and the Minister of Health on actions taken as a result of that engagement
Embed	• embed the needs and aspirations of Māori identified through engagement when: - co-developing and signing off the draft **NZ Health Plan** and health strategies - preparing a statement of intent and other applicable performance documents (e.g. an annual statement of performance expectations) - developing expectations on Health NZ to strengthen organisational performance for Māori (such as through a **Māori Health Plan**) - giving effect to government policy and the Authority's statutory purposes, including in approving other strategies, plans and frameworks which affect the Authority's activities.

What will the future look like?

When new services are commissioned or existing services are reviewed, the Māori Health Authority will work with Health NZ to make sure service design and priorities reflect diverse needs. Iwi-Māori Partnership Boards, which currently work with DHBs, will have an explicit, formal role – including agreeing local priorities with Health NZ

Health NZ will be responsible for improving Māori health outcomes and equity through all of its operational functions at national, regional and local levels

The Ministry of Health will continue to monitor how the system is delivering for Māori overall, partnering with the Māori Health Authority.

Appendix 2: Roles in a commissioning system

Regulators	**Regulators** focus on the relationship between service users and the provider. Regulators: • provide an independent assessment of policy, legislative or competition risks, and the impact (both intended and unintended) on providers and provider markets, service users, and the wider community • develop regulations to protect service users; this can include service accreditation requirements • enforce the rules within the commissioning system or market, including those related to contestability, sourcing and investing
Providers	**Providers:** Responsible for delivering a specified service, product or outcome to the customer against quality, timeliness and cost requirements. The provider can be from the government, private or non-government sectors.
Funders	**Contract managers** need to manage more than just the contract and invest in developing relationships with those who are delivering the response/service so that they are able to understand how results are being achieved. Ongoing monitoring requires regular conversations and discussions about how the model of care is working and how the contractual incentives and obligations are supporting innovative and integrated approaches. Monitoring may highlight were changes to the service design or delivery may need to change, for example to respond to unanticipated demand, or unmet need. The **policy maker** determines the legislative and policy framework and responses required to achieve the outcomes in the commissioning system. Policy makers also determine the: • level of funding that the commissioner has to purchase services or subsidise service users • sets the standards to be enforced by the regulator to protect service users • works with service commissioners to ensure the policy intent is achievable and service commissioners understand what is necessary to achieve the outcome. The **commissioner** provides the system governance and stewardship for overall service delivery the commissioner is responsible for maintaining the integrity and performance of the system and its integration always linking back to the policy-maker when evaluating outcomes and making adjustments to the commissioning systems to achieve the intent of the policy.
System	**Market steward,** the commissioner determines in the first instance what the structure of supply will be, the funding rules, and controls within the system. The commissioner will modify those rules and controls over time to protect the integrity of the service delivery system in achieving the desired outcomes. In cases where parts of the system fail, the commissioner plays a role in risk mitigation and business continuity. The commissioner may purchase services from providers on behalf of the service recipient, or the service recipient may receive subsidies from the commissioner and purchases services themselves. The commissioner may also have responsibility for defining eligibility for subsidies or for access to services by controlling cost and targeting specific customers.

Commented [JO65]: Regulations include those set out in the Health Practitioners Capability Assurance Act.
While not a regulator, the Health Quality & Safety Commission works to improve health quality and safety across the system, using its monitoring and reporting functions, best practice guidance, sector capability building and Partners in Care consumer engagement. https://www.hqsc.govt.nz/our-programmes/partners-in-care/

Commented [JO66]: General rules from the Public Finance Act, 1989, the Commerce Act 1986, NZ Health and Safety at Work Act 2015, employment law and occupational requirements will apply, along with ggovernment rules of sourcing, and the principles of government procurement.
Health-specific regulations are in the NZ Public Health and Disability Act 2000 and the Health and Disability Commissioner Act 1994.

Appendix X: Value chain analysis template

To add

Appendix X: Examples of other Commissioning Frameworks

Within New Zealand, commissioning frameworks have been developed by Whānau Ora commissioning agencies and District Health Board. There is also a social sector wide review on commissioning.

Social Sector Commissioning

MSD is leading the Social Sector Commissioning work programme which reports to Cabinet on what is needed to improve the quality, effectiveness and integration of commissioning across the social sector. Both the Pae Ora commissioning framework and the Commissioning for Equity and Wellbeing framework are aligned to, learning form, and influencing the social sector commissioning work. See https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/planning-strategy/social-sector-commissioning/index.html

Te Pou Matakana

The *Māori Commissioning Report* (Te Pou Matakana 2014) highlights the importance of looking at approaches that serve Māori and actively seek positive change within a kaupapa Māori framework. The review notes that although there is no definitive funding model designed specifically for Māori, Mason Durie has proposed several frameworks and guiding principles that can inform funding and help define funding outcomes from a kaupapa Māori perspective.

Whānau Ora commissioning

The Whānau Ora Results Commissioning Framework (Te Puni Kōkiri 2013) is depicted on a one- page table that has five high-level outcomes. Contracted commissioning agencies will determine commissioned activities to develop and support initiatives that will deliver measurable results for whānau and families that align with the Government's high-level Whānau Ora outcomes.

In the context of Whānau Ora, commissioning is described as 'the process of identifying the aspirations of whānau and families and investing in a portfolio of new or existing programmes or initiatives expected to best deliver progress towards Whānau Ora outcomes, as well as the monitoring, evaluation and review of these investments' (Te Puni Kōkiri 2013).

Mahura

The Strategic Partnership Agreement (SPA) between Te Rūnanga-Ā-Iwi-O-Ngāpuhi (TRAION) and Oranga Tamariki was signed in December 2018. The agreement formalises, records and promotes a strategic partnership and working relationship that meets both parties shared goals aspirations and visions.

Oranga Tamariki and TRAION have had a long working relationship in Tai Tokerau. Through TRAION's subsidiaries Ngāpuhi Iwi Social Services and Te Hau Ora o Ngāpuhi we have been delivering frontline social services to tamariki and whānau who live in or whakapapa to Ngāpuhi.

Ngāpuhi Iwi Social Services (NISS) provide the largest portion of contracted services for Ngāpuhi and are New Zealand's largest Māori social service provider. The SPA has further enhanced the already trusted relationship and provides both parties with clear goals and direction. This has enabled us to design, create and implement services that are specifically for whānau Māori such as Mahura

Mahuru has also won two separate awards, an Indigenous Service Award held by the Australia and New Zealand School of Government in Melbourne and the Most Innovative Procurement Award at last year's NZ Procurement Excellence Awards in Auckland.

Nuka System of Care, Alaksa

Southcentral Foundation is a non-profit health care organisation serving a population of around 60,000 Alaska Native and American Indian people in Southcentral Alaska, supporting the community through what is known as the Nuka System of Care (Nuka being an Alaska Native word meaning strong, giant structures and living things).

The Nuka System of Care incorporates key elements of the patient-centred medical home model, with multidisciplinary teams providing integrated health and care services in primary care centres and the community, co-ordinating with a range of other services. This is combined with a broader approach to improving family and community wellbeing that extends well beyond the co-ordination of care services – for example, through initiatives like Nuka's Family Wellness Warriors programme, which aims to tackle domestic violence, abuse and neglect across the population through education, training and community engagement.

Traditional Alaska Native healing is offered alongside other health and care services, and all of Nuka's services aim to build on the culture of the Alaska Native community

The Southcentral Foundation keep listening to what their community members are saying, go away to find ways of meeting their needs, and then return to feed back their progress. They have not always been able to achieve everything that members wanted, and had to be transparent and realistic about the limitations they were working with. But by listening, feeding back and being honest with their members, the local community understood that they were core partners in the transformation and delivery of care – 'walking with' the Southcentral Foundation through some challenging decisions.

Pae Ora
Commissioning Framework

*A te **Tiriti o Waitangi grounded, evidence-based** commissioning framework to deliver outcomes that **matter to whānau***

Changing commissioning at the system, strategic and service levels

Māori Health Directorate
Ministry of Health

ELT
27 October 2021

Our Kaupapa

The way we commission services is **impacting on whānau wellbeing and equity.**

The current commissioning **process** creates systemic barriers for **whānau to accessing services,** and for Māori providers to **start up, access funding** and become **sustainable**.

> "I **don't bother** with the health, justice or social funding [because of the process]
>
> *– A Māori drug and alcohol service provider*

> "Many of our people are not engaging with the system – the **system doesn't work for them** and they stand to lose a lot.
>
> *Hui Whakaoranga*

> "Māori providers are **over-audited** and heavily scrutinised and are **excluded** from the request for proposals processes.
>
> *Hui Whakaoranga*

These voices echo the concerns identified by Māori through *Te Piringa, Wai2575, Whakamaua/Whātua, Hui Whakaoranga, Wānanga Hauora and the engagement as part of the Māori Health Authority establishment.*

Bringing the Whānau Ora Vision into health and disability system

Enabling environment through H&DSR, Public Finance Act (wellbeing amendment) and Public Service Act 2020

Maturing approach

Te Tiriti principles in action: recognising the authority of Māori to manage their own health and wellbeing

	Services		Single Sector	Cross Sector	System
	Whanau Ora now	**Whanau Ora localised commissioning: 2019/20- 2022/23**	**Health and Wellbeing informed by the Whānau Ora vision and evolution to date**	**Social Sector commissioning**	**System Model transformation based on Whānau Ora and Te Piringa**
Delivery	Funding to providers and alliances for whānau-led support, using navigators, to help whānau articulate their aspirations, and get the support they need to realise them. Providers/alliances also receive funding from other agencies.	Testing new models to improve localised commissioning, including how mainstream services are delivered through Whānau Ora providers/ alliances.	Applying the learning from Whānau Ora to support providers to deliver health and disability services and support to whānau that understands and responds to their aspirations. Iwi Māori Partnership Boards Health NZ Commissioning for Equity and Wellbeing	Place-based Social Sector trials	Holistic and seamless services
Sectors	Te Pūni Kokiri Health Education Justice	Te Pūni Kokiri Health Education Justice	Māori Health Authority Ministry of Health Pae ora Commissioning Framework Public Health Agency	Joint Ventures Social Sector Commissioning	Unified Public service
Enablers			**Health and Disability System Review** • move from addressing equity within the system to changing how the system works to improve equity • move from short/medium term programmes to longer-term collaboration with the social sector • look at separating out functions/ new entities. **Wai2575**	**Public Finance Act 1989** • broaden focus to wellbeing • enable more flexible, cross-sector responses to complex issues • move away from compliance-based accountability and risk aversion • structure appropriations to support mobilised, cross-sector and longer-term investments	**Public Service Act 2020** • shift to whole-of-government action • shift to a unified public service • leaders take collective responsibility to respond to big challenges, eg poverty reduction

$ — Whānau ora vision investment — $$$$$$$$$

Whānau ora vision impact

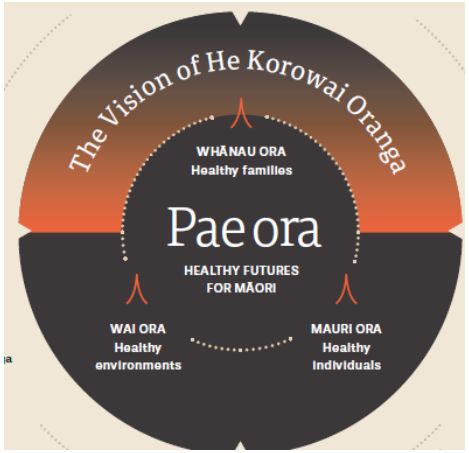
What makes this Commissioning Framework different?

We have many commissioning frameworks across our motu. Many of our Iwi Māori providers have their own frameworks. Why this?

Te Tiriti o Waitangi	• Grounded in Te Tiriti o Waitangi principles • Whakapapa back to Puao-te-Ata-tu, Te whare tapa whā, Whānau Ora, Wai 2575, Te Piringa research on bringing the Whānau Ora vision into primary and community care	**4 Whānau Ora vision** across health & disability system
1 What matters to whānau? Whānau self-defined, by whakapapa, aroha or kaupapa	• Starts with '**what matters to whānau** ' and at every commission stage they are always 'top of the page' • Non-clinical aspects of care including rongoā Māori and mātauranga Māori are valued as well as clinical aspects	
System, strategic & service levels	• Takes a broader view of commissioning and covers system impacts, strategic commissioning, provider capacity and capability, and market shaping, alongside the more usual focus on commissioning services	
2 **Māori world view, governance and decision-making**	It builds for the future, with the aim of devolving decision-making and funding as enabling environments are created for Māori to exercise: • Mana Whakahaere - stewardship • Mana Motuhake - the right for Māori to be Māori, to live on Māori terms • Mana Tangata - equity in health and disability outcomes • Mana Māori: ritenga Māori (rituals) framed by te ao Māori, enacted through tikanga and encapsulated within mātauranga Māori (Māori knowledge).	
Government requirements enable Te Ao Māori	• Government requirements mature so they enable Te Ao Māori approaches to commissioning • Funders and providers demonstrate how innovation fits within current Government requirements	
3 Ako We learn together	• Supported by cases studies of what works when commissioning for equity and wellbeing • Tested in a mix of learning partnerships, to understand '**what works for whānau**' • Aims to identify: - **system conditions** that need to change: eg mindsets, funding mechanisms, contracting practices - **enablers for success**: eg workforce, Te Tiriti, equity and anti-racism tools, funding IT infrastructure	

Shifting to whānau and Māori-led commissioning

Conventional commissioning starts with what matters to the system; whānau-shaped and Māori-led commissioning turns this on its head, and starts with **'what matters to whānau'**



	Conventional commissioning	Improved commissioning	
System	System knows what works best	System recognises whānau voice is needed	
Funder	Funders manage risk with highly specified contracts	Funders work with providers to design contract specs	Co-design of service
Provider	Providers are assessed against delivery (outputs)	Providers are assessed against delivery and outcomes	
Whānau	Whānau have services 'done to them'	Parts of the service reflect what matters to whānau	

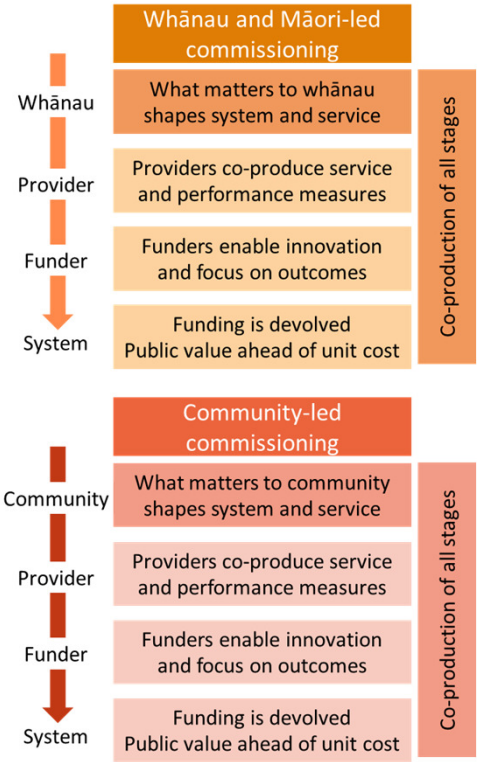
	Whānau and Māori-led commissioning	
Whānau	What matters to whānau shapes system and service	Co-production of all stages
Provider	Providers co-produce service and performance measures	
Funder	Funders enable innovation and focus on outcomes	
System	Funding is devolved Public value ahead of unit cost	

Pae Ora and Commissioning for Equity and Wellbeing

- These frameworks share the same DNA, are grounded in Te Tiriti o Waitangi principles and are evidence-based.
- They have been endorsed by Outcomes and Equity and Funding and Commissioning

These Commissioning Framework have two key aspects:

- there is a primary focus on what works for people and whānau, rather than prioritising what the system does; and
- they support cross-sector work, and the focus on enduring improvements for people, whānau and communities embedded in the Public Services Act (2020) and the Public Finance Act wellbeing amendments.



Pae Ora Commissioning Framework to guide current commissioning and provide potential insights for the Māori Health Authority and Iwi Māori Partnership Boards to help:

- improve the commissioning, and co-commissioning of health investments in collaboration with Health NZ and wider social sector agencies
- remove barriers to entry and sustainability for kaupapa Māori providers
- improve the capacity and capability building of kaupapa Māori providers
- understand what is needed to align work across the wider social sector to improve outcomes, including cross-sector commissioning, investment in provider capacity and capability and strategic (rather than reactive) provider market shaping.

Commissioning for Equity and Wellbeing Framework to:

- help guide the Ministry of Health in its current role as commissioner, and its future role (along with the Māori Health Authority) in monitoring Health NZ and the MHA's commissioning performance and results. This includes understanding key enablers (workforce, data and digital, performance monitoring and continuous improvement).
- provide guidance to the Public Health Agency on how the mix of levers (regulation, policy, commissioning and monitoring and evaluation) can be aligned to create stronger interventions

Frameworks can be applied across the whole system

The commissioning frameworks can be applied to public health, primary and community care and health and specialist services, noting there will also be specific requirements for each (eg a different order of capital investments for hospital and specialist services).

Commissioning frameworks
Equity & wellbeing Pae Ora

Enablers

- Te Tiriti o Waitangi principles
- Enabling 'what matters' to people, whānau, community
- Commissioning as an eco-system
- Strategic investment across levers (commissioning, policy, regulation)
- Co-production with whānau
- Evidence-based and innovative
- Collaboration with the social sector
- Funding directed to prevention and equity
- Funding flexibility and devolution
- Shared governance and decision-making
- Workforce pipeline
- Data infrastructure that supports insights

Outcomes

- Improved health and wellbeing
- Improved equity: communities, contexts, access and outcomes
- Increased choice and agency (options and rangatiratanga)
- Healthy and resilient people, whānau and communities
- Improved diversity and cultural safety (of providers, workforce)
- Sustainable and effective providers and provider markets
- Effective cross-sector collaboration
- Less wastage
- Improved public value

They can also be used for planning investments across the life-course, for different types of investments, and across the broader social sector.

Illustrating 'what works' in different world views

The current health and disability system does not work well for Māori. 'What works' for Māori can look different to what feels comfortable and acceptable to mainstream services.

Mainstream service

Bio-medical approach to recovery from trauma service

One-on-one counselling

Explore trauma

Therapeutic models to heal

Done in a clinical setting

Time limited sessions

Time limited period

Te Ao Māori perspective

Where is whānau?

How can healing come when it's just one person?

How is whakapapa recognised, and the impact on past, present and future generations?

Why is this done away from whānau and away from everyday life?

Is there time to build whanaungatanga ?

Is there time to recognise and build strengths?

Is there time to heal?

Western bio-medical mindset

How is patient confidentiality maintained?

Is this safe?

How are power dynamics managed?

Where is the evidence for this?

How can a trip to the beach heal trauma?

Is this an intervention government should pay for?

Kaupapa Māori service

Te Ao Māori approach to recovery from trauma service

Whole whānau is involved

Whakapapa is recognised, and the impact on past, present and future generations is used as part of the healing process

Whanaungatanga binds together

Mana is recognised and strengths are built on

Healing comes as part of doing everyday things together, going to the beach, building new relationships and sense of self and whānau

The enemies of innovation:

inertia, busyness, uncertainty

risk aversion, cynicism, racism

Changing how we think, act, fund etc

Think	• **Te Ao Māori contains kawa (knowledge) and tikanga (ways of working) that will improve outcomes** • **'What matters to whānau' shapes system and service design, delivery and assessment** • **Whānau have strengths and capabilities.** If this doesn't happen, the change is not real
Act	• We need to work together, and trust needs to be rebuilt between whānau, communities, providers and funders • We need to do new things; this will feel uncomfortable for many (eg, mainstream) and a relief to others.
Fund	• **Funding shifts to focus on 'what matters to whānau'** • **Strengths-based:** • Taha wairua — Lifting the spirit • Taha hinengaro — Focusing the mind • Taha tinana — Strengthening the body • Taha whānau — Enduring relationships If this doesn't happen, the change is not real
Deliver	• Services will become more holistic and integrated • Providers will be enabled to collaborate • Services deliver what is of value to whānau, and are enabled to stop doing things that aren't.
Assess	• Outcomes are measured in a way that is meaningful to whānau • Strengths-based outcomes are developed • Providers will shape monitoring and accountability requirements with funders, so insights are gained to support continuous improvement.
Improve	• **The evidence of 'what works for whānau' reshapes services and future investments** • **Stopping services that no longer deliver what matters to whānau is supported** • **Over time, more funding is shifted from reactive responses to prevention.** If this doesn't happen, the change is not real

What maturity looks like across the commissioning system

As commissioning levers are applied, each level experiences increasing levels of commissioning maturity. The journey will take time, and trust. But every small step helps.

	Current state	1-2 years	3-5 years	10 years
WHĀNAU 	Get what the system thinks they want Are seen as passive recipients in their health and wellbeing journey Seen as 'problems to be solved'	Can exercise choice over what service and support they use Enabled to be active participants in their health and wellbeing journey Services work with the whole whānau	The right support can be accessed easily, and early on: - in life, and - in the life of a problem	Experience seamless access to whānau-centred services across the life course Strong health literacy 'Core economy' of people, whānau, community is strengthened; social connections rebuilt and flourish
PROVIDERS 	High compliance costs across piecemeal contracts Funding approaches make it hard to attract, train and retain staff	Deeply understand the community and context Whanaungatanga and building strong, trusted relationships is valued Co-produce whānau-centred, culturally safe services	Continuous improvement includes clinical, cultural and community insights Innovation embedded Can attract and retain skilled workers	Enabled to work collaboratively with other services Leadership supports innovation and adaptive management; services and staff can flex to meet new challenges and opportunities
FUNDERS 	Low trust Outputs focused contracts Deficit and disease focused Siloed approach Application process favours larger providers with good bid writers	Contextualised understanding Enable high trust relationships and encourage innovation Process supports diverse provider pool Contracts support outcomes Monitoring builds insights	Take a capability building approach; for providers, and for whānau and community Collaborate across the social sector, and collective accountability Funding and other support to ember innovation	Devolved funding and decision-making Broader provider pool get funding Whānau outcomes and innovation are incentivised Health, wellbeing and equity outcomes improve
SYSTEM 	Lack of clarity of roles and purpose, leading to gaps, overlaps and wastage Problems need to escalate to reach thresholds for action	Investment focuses on prevention and broader determents of health and wellbeing (causes, not symptoms) Workforce pipeline to meet changing demand, collaborative working and outcomes-focus	Strategic collaboration to create seamless services for whānau across the life course Effective surveillance and smart analytics inform policy and investment strategies, and identify where other tools eg regulation are needed	Investments are guided by evidence, te Tiriti principles, whānau voice, robust data and forecasts. "Wastage', and human and financial costs are reduced as system agents work well together Sustainable investment and effective workforce pipeline

Web portal for commissioning resources

WHY we need to change, WHAT we need to change and HOW we need to change – with tools, resources, case studies, videos

It is iterative, and will reflect new insights. It includes what is needed from health sector entities, the social sector and Treasury to enable successful implementation.

The Pae Ora Commissioning Framework is a collection of taonga that have been tākoha to support different stakeholders

Introduction
video explaining the what, why, who, how

Whakapapa
for the development of the framework

Definitions
eg commissioning, whānau, what is a 'kaupapa' provider

Policy alignment
strategic context

Application
as Reforms are implemented

2 Mana Whakahaere, Mana Motuhake, Mana Tangata and Mana Māori

Commissioning Framework

with examples, tools and guidance linked to each stage of the process.

1 What matters to whānau

Purpose and Understanding

Planning and designing

Sourcing and investing

Delivery and improvement

3 Ako
we learn together

Examples to inspire

- **Case studies:** Whānau Ora, innovative procurement, equity, community focus
- Māori Health Service Improvement **innovation fund**
- **Videos** and key tips from providers, contract managers, funders

Te Tiriti and equity tools:

HEAT and Equity by Design
Te Tiriti Tools
Mātauranga Māori Framework

Co-design tools and examples

https://www.ideo.com/post/design-kit

What matters to whānau in design of services and what is measured

Reporting tools that provide insights and are easy to use

Innovation

Procurement approaches eg videos, te reo

Capability and sustainability

of existing Māori providers and supporting new ones into the market

Outcomes, continuous improvement

Results, lessons learnt

Systems improvements

Policy & regulatory changes
Enablers needed

Strategic priorities

for investment

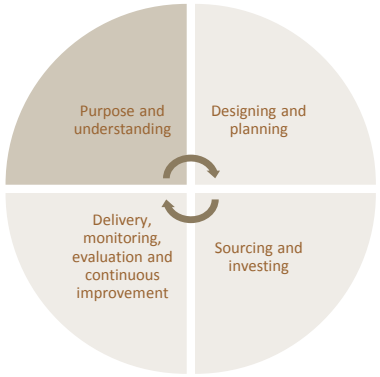
4 Whānau Ora vision across health & disability system

Better Business Cases | **Sourcing rules and procurement principles** | **Government accountability requirements**

1. Purpose and understanding

Key shifts and enablers

Aim: To understand and define the need or opportunity, the outcomes wanted, what's already known to work, and readiness for action.



	From conventional commissioning	To whānau-shaped and Māori-led
Whānau	• Services are not designed around what matters to whānau	• Service users and whānau shape system and service purpose so it delivers 'what matters to them'
Providers	• Providers' expertise in delivery, and understanding of local contexts and communities is not drawn on	• Providers are engaged in the design of new approaches • Providers shape meaningful performance measures that explain variance in outcomes and support continuous improvement
Funders	• Top-down approach stops innovation • Funding follows historical patterns • Narrow range of options considered • Efficiency and unit cost to deliver services are used as measures of value.	• Enable design thinking with diverse inputs, and ensure service users, potential service users and whānau shape the system and service purpose, and the outcomes that matter to them • Enable thinking around 'what's possible' • Use theories of change and staged approaches to manage uncertainty • Costs across the system and public value replaces unit costs analysis.
System	• Provider failure, or service users not trying hard enough are seen as the main reasons why outcomes have not improved as hoped.	• System conditions are recognised as impacting on outcomes, including what evidence is valued, how innovation is enabled, and the impact of systemic and institutional racism on service design.

Enablers	Shorter-term	Longer-term
Ministry of Health	Prepare the sector and Ministers for a change in the types of services that will be commissioned Exercise leadership and courage as services change to deliver what matters to whānau	Monitor the extent to which service and system purpose has been shaped by whānau for all commissioning agents in the health and disability system Enable joint work programmes across Māori Health Authority, Health NZ and the Public Health Agency
Public Health Agency	Provide population-level data and insights into health inequities, root causes and factors that drive persistent disadvantage Share public health methods that could support system and service design to deliver what matters to whānau	Develop and implement other levers to compliment commissioning; for example regulatory levers to shape food environments.
HQSC	Provide insights from the consumer networks	Enable a broader network of service user engagement
Health NZ	Collaborate with IMPBs to understand what matters to whānau and support their priorities for action	Use strategic and longer-term advice from IMPBs on areas for investment.
Māori Health Authority	Develop strong, high trust relationships with IMPBs Act on guidance from IMPBs on what matters to whānau at the locality and regional levels	Use advice from IMPBs to develop areas for strategic investment and system-level change
Iwi Māori Partnership Boards	Deep connection with, and understanding of, whānau, communities and contexts Resources, design thinking and engagement processes to: • capture 'what matters to whānau' • contextualise what matters to whānau • identify common themes across rohe and motu • influence system and service purpose, so it reflects 'what matters to whānau' identify capability needs to support whānau engage in shaping system and service purpose Identify system conditions that make it hard to determine what matters to whānau	Build the kete to capture what matters to whanau, including identifying emerging and unmet need. Consolidate common themes, and make recommendations on changes needed at a system level Build succession-planning so there rangatahi start to gain experience, insight and leadership
Social sector	Collaboration with the Social Sector Commissioning work programme	Coordination of engagement with Māori, to reduce consultation fatigue
Te Puni Kōkiri	Share lessons learnt from managing and evolving Whānau Ora from a service, to a provider, to a commissioning agency	Provide guidance on how to shape 'what matters to whānau' in a way that reflects Te Ao Māori framing
Treasury	Clear articulation of the purpose of agency funding Macro-level influences on demand Emerging issues	Review of system and service purpose identified from commissioning work in the health and social sectors, to build a broader view of what matters to whānau

Pathways and priorities

- Earlier versions of the frameworks have been shared with the TU. Their current commissioning workshops are by invite only.
- ELT guidance sought on priorities and pathways for influence.

Potential areas for influence going forward:

- joint TU Hauora Māori and MOH Māori Health Directorate work on how the ideas can be incorporated into the Health Plan
- develop implementation-focused resources with commissioning experts across the Ministry, with a focus on:
    - prioritisation
    - contracts
    - assessing outcomes
    - data infrastructure

Case studies: learning from others

The case studies capture insights from commissioning in different contexts and with different partners, with the aim of understanding how to apply these insights as the Health and Disability System reform recommendations are enacted.

The case studies cover 8 key themes, from applying insights from Whānau Ora's evolution into the health and disability system, using innovation in procurement to build the kaupapa Māori mental health services, to supporting long-term cross-sector collaboration. Most of the case studies provide insights across the commissioning cycle; below they are grouped against the key stages they illuminate.

Completed		Case study purpose	Insights and future application
Purpose	1	Capturing insights from Te Pūtahitanga o Te Waipounamu (South Island Whānau Ora Commissioning Agency) in innovative commissioning approaches, where whānau are supported to develop localised solutions. The case study also sets out the broader evolution of Whānau Ora from a provider-based response to a collective, then a commissioning agency.	The aim is to distil and transfer insights from Whānau Ora's implementation and evolution, so the health and disability system can learn how to support whānau on their health and wellbeing journey in ways that matter to them.
Understanding	2	Te Ranga Ora in Counties Manukau shows a community-initiated response to treating and preventing long-term conditions, like diabetes and heart disease. Counties Manukau Health now supports five distinct community-developed prototypes, all in different stages of operation.	The Te Ranga Ora case study highlights what is needed to support community-initiated responses at the design stage, as well as how to retain community leadership once services are operational.
Planning and designing	3	Designing the journey of system transformation in the disability sector to enable people to live good lives, looking at Mana Whaikaha in Palmerston North.	The Mana Whaikaha case study looks at flexible funding as one of the first key steps to enabling disabled people choice in what services and support they receive as part of their care. This needs to be supported by changes in mindsets (ie recognising that disabled people know what is best for themselves), workforce training and leadership.
Sourcing and investing	4	District Health Boards are the main commissioners for health and disability services in their areas. Examples of equity-focused commissioning of services are captured from four DHBs (Lakes, Mid-Central, Hawkes Bay and Tairāwhiti).	These DHB case studies will highlight different approaches used, at the local and regional levels, with a focus on community-led and whānau-centred services. Perspectives will be shared from both DHB and providers.
	5	The Ministry of Health's Mental Health Directorate used innovative approaches to procurement, eg video applications in te reo Māori, to help encourage new kaupapa Māori providers into the mental health sector.	This case study shows how innovation in procurement can help attract new kaupapa Māori mental health service providers and improve service options for whānau. *"Innovation in procurement practice is the most likely path to innovation in service delivery"*
Delivery	6	Most of the barriers to medicine adherence are created by the way the health system operates. Poor medicine adherence has a greater impact on people with long-term conditions, Māori, Pacific people and rural/remote communities, ZOOM Pharmacy combines understanding consumer preference, removing barriers to access and supporting medicine adherence.	The ZOOM Pharmacy case study focuses on the interaction between a commercial entity and social entrepreneur and the health system, to understand how to harness entrepreneurial responses which improve equity while meeting system stewardship obligations.
Monitoring and evaluation	7	Greater cross-sector collaboration is needed to address inequity in health and wellbeing. The National Telehealth services is a long-term cross-sector contract to create a flexible telehealth environment that can evolve and respond to new opportunities and changing contexts (eg Covid).	The National Telehealth case study focuses on what was needed to support cross-sector commissioning over a long time period (10 years), what benefits has it produced, and lessons for the future.
	8	Healthy Families NZ takes a cross-sector and community development approach to improving health and wellbeing. It focuses on building capacity and resilience within communities to prevent long-term conditions like diabetes.	The Healthy Families case study provides insight into how to commission and report on the collective impact of working with communities, NGOs, providers and mainstream services to prevent long-term conditions. The focus is on building the 'core economy' of family, whānau and community, to complement traditional service-based responses. ** The art of the possible in public procurement, Frank Villeneuve-Smith and Julian Blake (2016)

Learning partnerships

Key learning partnerships have been established to test and refine understanding of what it means to commission for equity and wellbeing (covered next page), so these insights can help shape guidance, tools and templates available. In some of these learning partnerships, the Māori Health Directorate is leading the work, and in others it is in an influence role.

Focus	Learning partnerships;	MHD role	Learning partners: Māori Health Policy and…
Innovation	The Te Ranga Ora (TRO) learning partnership will assess the effectiveness of five community-initiated prototypes in treating and preventing long-term conditions (LTCs) with a whānau-focus. The Turuki Health Mobile Outreach contract recreates the permissive contracting environment used during the Covid-19 nationwide lock down in 2020, supplemented with an agreement to extract data on actual service provision (rather than narrowly prescribe services, when demand is unknown).	Influence Lead	Population Health & Prevention Te Ranga Ora prototypes Counties Manukau Health Kaupapa Māori service providers
Addressing gaps	Tamariki in contact with Oranga Tamariki (OT) have the lowest enrolment with GPs and are more likely to have missed key health checks (eg Before School) than any other group of children. The Māori Health Directorate were asked to take a pragmatic response to this issue by its external Māori Advisory board. Amid wider system and service improvements, this initiative is focused on what can be done now to ensure primary health care services reach tamariki in contact with Oranga Tamariki and their whānau. Understanding how this group fall between existing commissioned services will be the first step. The discovery phase may provide sufficient insights to guide action, but a protype may be needed to test options.	Lead *(discovery phase)*	Oranga Tamariki
Strategic investment	How to be a good commissioner of kaupapa services and mātauranga Māori Capture insights from the Māori Health Directorate's Māori Health Services Improvement team on how to strengthen kaupapa Māori services and mātauranga Māori through commissioning, including contracting and reporting requirements. These insights will be consolidated with research from Māori providers' perspectives, drawn from the literature (eg Te Piringa) as well as testing with a sample of providers, and developed into a practical guide.	Lead	Māori Health Services Improvement team Kaupapa Māori service providers
	Population Health and Prevention's Investing in Wellbeing Over the next two years Population Health and Prevention's **Investing in Wellbeing** work programme will explore different ways of commissioning to: • improve wellbeing outcomes for Māori, Pacific people and those living in areas of economic deprivation; and • strengthen provider innovation and develop and spread effective kaupapa Māori and whānau-centred services. Contracts with national service providers will be reviewed and around $11m health promotion funding currently directed to services for nutrition and physical activity, alcohol and other drugs reinvested.	Influence	Population Health and Prevention Māori Health Services Improvement team
System enablers	Enabling innovation within existing procurement and contracting environments There is often more scope for innovation within existing legislation and procurement rules, but practices have normalised narrower interpretations. What can be done now is to ensure procurement advisors and contract managers are part of the journey of supporting innovation in service and system design, as well as providing expertise on how to meet accountability requirements.	Co-lead *with MOH procurement*	*Initially* Ministry of Health Procurement MSD Social Sector commissioners
	Learning from and contributing to the wider Social Sector commissioning programme Learning from and contributing to the wider Social Sector Commissioning work programme, noting the importance of the social sector to addressing the broader social, economic and behavioural determinates of health. The consultation process has now ensured te Tiriti of Waitangi is the starting point of transforming social sector commissioning. Work is now underway to change behaviour, practice and systems to improve outcomes for whānau and communities.	Influence	*Later* Treasury Ministry of Business, Innovation and Employment.

Pae Ora (Healthy Futures) Bill

Government Bill

Explanatory note

General policy statement

Successive reviews of the publicly-funded health system in New Zealand, most recently the independent Health and Disability System Review that was released in June 2020, have found consistently poor outcomes for some groups, in particular Māori, Pacific peoples, and people with disabilities, and significant unwarranted variation in service availability, access, and quality between population groups and areas of New Zealand. For Māori in particular, the health system does not operate in partnership and does not meet the Crown's obligations under te Tiriti o Waitangi (the Treaty of Waitangi).

The Health and Disability System Review identified that one of the root causes of this inequity and variation was the structure of the health system. It described a system that had become fragmented and complex, leading to unclear roles, duplication, misalignment, and a lack of a common whole-system ethos.

Tackling these issues requires reform that fundamentally changes the structure and accountability of the publicly-funded health system, making it necessary to repeal and replace the New Zealand Public Health and Disability Act 2000 in its entirety.

This Bill addresses these issues and provides for a new structure and new accountability arrangements. The purpose of the reforms is to:

- protect, promote, and improve the health of all New Zealanders; and
- achieve equity by reducing health disparities among New Zealand's population groups, in particular for Māori; and
- build towards pae ora (healthy futures) for all New Zealanders.

Giving effect to principles of te Tiriti o Waitangi (the Treaty of Waitangi)

The Bill is intended to give effect to the principles of te Tiriti o Waitangi (the Treaty of Waitangi). A descriptive clause sets out the provisions that give effect to the

Crown's obligations. The Bill also sets out principles that will guide decision-makers, incorporating the concepts of the principles for the health system discussed by the Waitangi Tribunal in the WAI 2575 Inquiry. This places Tiriti/Treaty-informed decision-making at the heart of the system by ensuring that decisions made by health entities will be genuinely informed by the health principles identified by the Tribunal, and that the legislation will support system-wide accountability for Māori health outcomes.

Health system structures

The Bill disestablishes district health boards and the Health Promotion Agency. Their assets, liabilities, contracts, and employees will transfer to new entities. All transferring employees will retain their existing terms and conditions of employment on transfer, including arrangements that had been specific to particular district health boards.

Health New Zealand

The Bill establishes Health New Zealand, a new Crown agent to lead system operations, planning, commissioning and delivery of health services, working with the Māori Health Authority. Health New Zealand will establish localities to plan and commission primary and community health services effectively and engage with communities at the appropriate level. This will reduce system complexity and enable consistency, a population health focus, and meaningful community and consumer participation in the planning, delivery, and monitoring of health services.

Māori Health Authority

The Bill establishes the Māori Health Authority to drive improvement in hauora Māori. The Authority will be an independent statutory entity with clear accountabilities to both Māori and the Crown. It will co-commission and plan services with Health New Zealand, commission kaupapa Māori services, and monitor the performance of the system for Māori. The Authority will work with the Ministry of Health to prepare national strategies and provide advice to the Minister. The Bill also requires the Minister to establish a Hauora Māori advisory committee to advise on the exercise of Ministerial powers in relation to the Authority

Iwi-Māori partnership boards

The Bill provides a statutory purpose and framework for recognising iwi-Māori partnership boards as a vehicle to exercise tino rangatiratanga and mana motuhake at the local level. The interim Māori Health Authority is leading a process of engagement to advise on the specific functions and powers the partnership boards should have, and changes are anticipated during the passage of the legislation.

Public health

The Ministry of Health will continue to act as chief steward of the health system with a focus on strategy, policy, regulation, and monitoring. A new Public Health Agency

will be established as a business unit within the Ministry of Health to provide system leadership for public health and advise the Director-General on public health matters. The role of the Director of Public Health as a system leader will be strengthened. The Bill also requires the Minister to establish an expert advisory committee to provide independent advice on issues relating to public health.

Strategic, accountability, and monitoring documents

The Bill establishes a more cohesive system focused on long-term strategic direction and population health needs, providing for a number of key health system strategic, accountability, and monitoring documents:

- the Government Policy Statement on Health, which will set out the government's overall direction, priorities, and objectives for the health system. It must be issued by the Minister at intervals no longer than 3 years; and
- National health strategies—the New Zealand Health Strategy will provide a framework for the overall 5–10 year direction of the health system and must be prepared and determined by the Minister. The Minister must also prepare and determine Hauora Māori, Pacific Health, and Disability Health strategies that include specific consideration of outcomes and performance for Māori, Pacific, and disabled peoples; and
- the New Zealand Health Plan, which will set the operational direction for the system and is to be jointly prepared by Health New Zealand and the Māori Health Authority; and
- locality plans, which will assess health needs at the local level and are to be jointly agreed by Health New Zealand and the Māori Health Authority; and
- the New Zealand Health Charter, which will provide common values, principles, and behaviours for organisations and workers in the health system; and
- the Code of Consumer Participation, which will support consumer participation and enable the consumer voice to be heard.

Continuation of some existing statutory provisions

Part 3 of the Bill continues Pharmac, the New Zealand Blood and Organ Service, and the Health Quality and Safety Commission (**HQSC**) They will continue to exercise their current functions, subject to the accountability and monitoring requirements in the Bill, and minor amendments to reflect a stronger role for HQSC in supporting consumer engagement.

Part 3 also continues provisions relating to ministerial committees. *Part 4* continues general administrative requirements that apply to health entities.

Schedule 1 set out transitional, savings and related provisions. This includes the transfer of district health board assets and liabilities. *Schedules 4 and 6* replicate relevant schedules of the New Zealand Public Health and Disability Act 2000.

Departmental disclosure statement

The Department of the Prime Minister and Cabinet is required to prepare a disclosure statement to assist with the scrutiny of this Bill. The disclosure statement provides access to information about the policy development of the Bill and identifies any significant or unusual legislative features of the Bill.

A copy of the statement can be found at http://legislation.govt.nz/disclosure.aspx?type=bill&subtype=government&year=2021&no=85

Regulatory impact statement

The Department of the Prime Minister and Cabinet produced a supplementary analysis report on 2 June 2021 and a regulatory impact statement on 2 September 2021 to help inform the main policy decisions taken by the Government relating to the contents of this Bill.

Copies of these documents can be found at—

- https://www.dpmc.govt.nz/publications
- https://treasury.govt.nz/publications/informationreleases/ris

Clause by clause analysis

Clause 1 is the Title clause.

Clause 2 is the commencement clause. The Bill comes into force on 1 July 2022.

Part 1
Preliminary provisions

Clause 3 states the purpose of the Bill.

Clause 4 defines terms used in this Bill.

Clause 5 is an outline provision.

Clause 6 describes how this Bill provides for the Crown's intention to give effect to the principles of te Tiriti o Waitangi (the Treaty of Waitangi).

Clause 7 sets out the health system principles for the purpose of the Bill.

Clause 8 gives effect to transitional and savings provisions which are set out in detail in *Schedule 1*.

Clause 9 provides that the Bill, when enacted, will bind the Crown.

Part 2
Key roles and health documents

Subpart 1 provides an overview of the Minister's role in the health system.

Subpart 2 relates to Health New Zealand and provides for the following:

- the establishment of Health New Zealand as a Crown agent to which the Crown Entities Act 2004 applies:
- the membership of its board, which must comprise a total of not more than 8 but not fewer than 5 members appointed by the Minister:
- the objectives and functions of Health New Zealand.

Subpart 3 provides for the establishment of the Māori Health Authority and provides for—

- the membership of its board, which must comprise a total of not more than 8 but not fewer than 5 members appointed by the Minister after consulting with the Hauora Māori advisory committee:
- the objectives and functions of the Māori Health Authority:
- the application of the Crown Entities Act 2004, Public Service Act 2020, and the Public Records Act 2005 to the Māori Health Authority.

Subpart 4 provides a means by which disputes are to be resolved if Health New Zealand and the Māori Health Authority disagree on a matter that they are required under this Act to work together on, jointly develop, or agree. If their chief executives are unable to resolve the dispute between themselves, they must refer the dispute to the Minister. The Minister may determine the dispute or a process to resolve the dispute, the outcome of which the parties must comply with.

Subpart 5 requires the making of the following key health documents for the health system:

- the Government Policy Statement for health:
- the New Zealand Health Strategy, Hauora Māori Strategy, Pacific Health Strategy, and the Disability Health Strategy:
- the New Zealand Health Plan:
- the New Zealand Health Charter:
- the Code of Consumer Participation:
- Locality plans.

Subpart 6 enables the Minister to—

- appoint Crown observers to attending meetings of Health New Zealand or the Māori Health Authority if the Minister considers it desirable for the purpose of assisting in improving the performance of that health entity:
- require a health entity to prepare and implement an improvement plan if the Minister believes on reasonable grounds it is necessary to improve the performance of the health entity:
- dismiss the board of Health New Zealand or the Māori Health Authority if the Minister is seriously dissatisfied with the board's performance:
- appoint a commissioner to replace a board that has been dismissed above or removed from office under Crown Entities Act 2004 (the agreement of the

Hauora Māori advisory committee is required in relation to the board of Māori Health Authority).

Part 3
Other roles

Subparts 1 to 4 continues the roles of the following health entities established under the New Zealand Public Health and Disability Act 2000 (**former Act**):

- Pharmac:
- New Zealand Blood and Organ Service:
- Health Quality and Safety Commission.

Subpart 5—

- provides for the establishment of ministerial committees; and
- requires the establishment of a Hauora Māori advisory committee whose functions include advising the Minister on matters relating to the Māori Health Authority; and
- requires the establishment of a national advisory committee on health services ethics and an expert advisory committee on public health (this requirement is carried forward from the former Act).

Subpart 6 provides for Iwi-Māori partnership boards and sets out the criteria and process for the recognition of Iwi-Māori partnership boards. The purpose of iwi-Māori partnership boards is to represent local Māori perspectives on—

- the needs and aspirations of Māori in relation to hauora Māori outcomes; and
- how the health system is performing in relation to those needs and aspirations; and
- the design and delivery of services and public health interventions within localities.

An organisation listed in *Schedule 3* is recognised as the iwi-Māori partnership board for the area that it covers. That schedule may be amended in accordance with *clause 88*.

Part 4
General

Part 4 provides for general matters and contains—

- provisions relating to funding agreements and arrangements relating to payments; and
- provisions that apply to all health entities; and
- powers relating to the making of secondary legislation.

Schedules

Schedule 1 relates to the transition of health system arrangements under the former Act to the Pae Ora (Healthy Futures) Act 2021. Schedule 1 provides for—

- certain provisions of the Bill to take effect at a later date and provides for interim measures until they take effect:
- the continuation of the New Zealand disability strategy made under the former Act:
- the disestablishment of DHBs and the transfer of assets, liabilities, and other matters from DHBs to Health New Zealand:
- the disestablishment of the Health Promotion Agency and the transfer of assets, liabilities, and other matters from the agency to Health New Zealand:
- the transfer of employees to Health New Zealand, including the effect of the transfer on collective agreements covering employees of DHBs:
- the continuation of ministerial directions and notices relating to payment arrangements made under the former Act:
- the continuation of ministerial committees and other committees established or appointed under the former Act.

Schedule 2 provides for consequential amendments to Acts and secondary legislation.

Schedule 3 lists the names of iwi-Māori partnership boards and the areas that they cover.

Schedule 4 continues the provisions that apply to mortality review committees appointed by HQSC.

Schedules 5 and 6 are carried forward from the former Act and relate to levies that may be imposed for alcohol related purposes.

Hon Andrew Little

Pae Ora (Healthy Futures) Bill

Government Bill

Contents

The Parliament of New Zealand enacts as follows:

1 Title

This Act is the Pae Ora (Healthy Futures) Act **2021**.

2 Commencement

This Act comes into force on 1 July 2022.

Part 1
Preliminary provisions

3 Purpose of this Act

The purpose of this Act is to provide for the public funding and provision of services in order to—

(a) protect, promote, and improve the health of all New Zealanders; and

(b) achieve equity by reducing health disparities among New Zealand's population groups, in particular for Māori; and

(c) build towards pae ora (healthy futures) for all New Zealanders.

4 Interpretation

In this Act, unless the context otherwise requires,—

Code of Consumer Participation means the Code of Consumer Participation approved under **section 53**

Crown funding agreement means an agreement that the Crown enters into with any person under which the Crown agrees to provide money in return for the person providing, or arranging for the provision of services, facilities, or goods specified in the agreement

Director-General means the chief executive or acting chief executive under the Public Service Act 2020 of the Ministry of Health

disability support services includes goods, services, and facilities—

(a) provided to people with disabilities for their care or support or to promote their inclusion and participation in society and their independence; or

(b) provided for purposes related or incidental to the care or support of people with disabilities or to the promotion of the inclusion and participation in society of such people and their independence

Government Policy Statement or **GPS** means the Government Policy Statement on Health required under **section 30**

Hauora Māori advisory committee means the committee established under **section 84**

health entity means Health New Zealand, HQSC, the Māori Health Authority, Pharmac, or NZBOS

Health New Zealand means the health entity established under **section 11**

health strategy means any of the following health strategies:

(a) the New Zealand Health Strategy:

(b) the Hauora Māori Strategy:

(c) the Pacific Health Strategy:

(d) the Disability Health Strategy

health system means all of the following entities, and includes activities funded by them:

(a) the Ministry (including its departmental agencies); and

(b) all health entities; and

(c) the Mental Health and Wellbeing Commission, the Health and Disability Commissioner, the New Zealand Artificial Limb Service, and the Health Research Council of New Zealand

health system principles means the principles set out in **section 7(1)**

HQSC means the Health Quality and Safety Commission continued under **section 71**

iwi-Māori partnership board means an organisation listed in **Schedule 3**

locality means a geographically defined area determined under **section 48**

Māori Health Authority means the health entity established under **section 17**

Minister or **Minister of Health** means the Minister of the Crown who, under the authority of any warrant or with the authority of the Prime Minister, is responsible for the administration of this Act

Ministry or **Ministry of Health** means the department of the public service referred to by that name

ministerial committee means a committee established under **section 82**

New Zealand Health Charter or **charter** means the charter made under **section 52**

New Zealand Health Plan means the plan required under **section 44**

New Zealand Health Strategy means the strategy required under **section 37**

NZBOS means the New Zealand Blood and Organ Service continued under **section 68**

personal health means the health of an individual

personal health services—

(a) means goods, services, and facilities provided to an individual for the purpose of improving or protecting the health of that individual, whether or not they are also provided for another purpose; and

(b) includes goods, services, and facilities provided for related or incidental purposes

Pharmac means the Pharmaceutical Management Agency continued under **section 60**

pharmaceutical means a medicine, therapeutic medical device, or related product or related thing

pharmaceutical schedule means the list of pharmaceuticals for the time being in force that states, in respect of each pharmaceutical, the subsidy that the Crown intends to provide for the supply of that pharmaceutical to a person who is eligible for the subsidy

provider means a person who provides, or arranges for the provision of, services

public health means the health of—

(a) all the people of New Zealand; or

(b) a population group, community, or section of people within New Zealand

Public Health Agency means the Public Health Agency established under section 3E of the Health Act 1956

public health services means goods, services, and facilities provided for the purpose of improving, promoting, or protecting public health or preventing population-wide disease, disability, or injury, and includes—

(a) regulatory functions relating to health or disability matters; and

(b) health protection and health promotion services; and

(c) goods, services, and facilities provided for related or incidental functions or purposes

publicly available, in relation to a document, means to publish it in a readily accessible format on an Internet site that—

(a) is administered by or on behalf of the Ministry or a health entity; and

(b) is publicly available as far as practicable and free of charge

services means—

(a) personal health services; and

(b) public health services; and

(c) disability support services; and

(d) services provided to a person who has requested assisted dying under the End of Life Choice Act 2019

statement of intent means a statement of intent prepared in accordance with the Crown Entities Act 2004 and any regulations made under this Act.

5 Guide to this Act

(1) **Part 1** provides for the purpose of this Act, the health system principles, and definitions and sets out how this Act provides for the Crown's intention to give effect to the principles of te Tiriti o Waitangi (the Treaty of Waitangi).

(2) **Part 2** provides for the roles of the Minister of Health, Health New Zealand, and the Māori Health Authority. **Part 2** also provides for the key health documents that will inform the provision of services under this Act.

(3) **Part 3** sets out the role of Pharmac, HQCS, NZBOS, specified committees, and iwi-Maori partnership boards and provides for the establishment of ministerial committees.

(4) **Part 4** contains powers relating to service commissioning, provisions that apply to health entities, and empowers the making of secondary legislation.

(5) This section is intended as a guide only.

6 Te Tiriti o Waitangi (the Treaty of Waitangi)

In order to provide for the Crown's intention to give effect to the principles of te Tiriti o Waitangi (the Treaty of Waitangi), this Act—

(a) requires health entities to be guided by the health system principles, which, among other things, are aimed at improving the health system for Māori and raising hauora Māori outcomes; and

(b) establishes the Māori Health Authority and sets out its objectives and functions; and

(c) requires the Minister to—

(i) establish a permanent committee, the Hauora Māori advisory committee, to advise the Minister; and

(ii) seek the advice or agreement of the committee before exercising certain powers; and

(d) gives recognition to iwi-Māori partnership boards to enable Māori to participate in and contribute to decision making on local health priorities; and

(e) requires Health New Zealand and the Māori Health Authority to engage with iwi-Māori partnership boards; and

(f) requires Health New Zealand and the Māori Health Authority to jointly develop and implement a New Zealand Health Plan and to work together in the performance of specified functions of Health New Zealand; and

(g) requires the boards of Health New Zealand and the Māori Health Authority to have knowledge of, and experience and expertise in relation to, giving effect to te Tiriti o Waitangi (the Treaty of Waitangi) and tikanga Māori; and

(h) requires the Māori Health Authority to have systems in place for the purpose of engaging with Māori and enabling the responses from that engagement to inform the performance of its functions; and

(i) requires the Māori Health Authority to report back to Māori on how the engagement under **section 20(1)(c)** has informed the performance of its functions.

7 Health system principles

(1) For the purpose of this Act, the health system principles are as follows:

(a) the health system should be equitable, which includes ensuring Māori and other population groups—

(i) have access to services in proportion to their health needs; and

(ii) receive equitable levels of service; and

(iii) achieve equitable health outcomes:

(b) the health system should engage with Māori, other population groups, and other people to develop and deliver services and programmes that reflect their needs and aspirations, for example, by engaging with Māori to develop, deliver, and monitor services and programmes designed to raise hauora Māori outcomes:

(c) the health system should provide opportunities for Māori to exercise decision-making authority on matters of importance to Māori and for that purpose, have regard to both—

(i) the strength or nature of Māori interests in a matter; and

(ii) the interests of other health consumers and the Crown in the matter:

(d) the health system should provide choice of quality services to Māori and other population groups, including by—

(i) resourcing kaupapa Māori and whānau centred services; and

(ii) providing services that are culturally safe and culturally responsive to people's needs; and

(iii) harnessing clinical leadership, innovation, and technology to continuously improve services; and

(iv) providing services that are tailored to a person's circumstances and preferences; and

(v) providing services that reflect mātauranga Māori:

(e) the health system should protect and promote people's health and wellbeing, including by—

(i) adopting population health approaches that prevent, reduce, or delay the onset of health needs; and

(ii) undertaking promotional and preventative measures to protect and improve Māori health and wellbeing; and

(iii) working to improve mental and physical health and diagnose and treat mental and physical health problems equitably.

(2) A health entity must, when performing its functions under this Act, be guided by the health system principles—

(a) as far as reasonably practicable, having regard to all the circumstances, including any resource constraints; and

(b) to the extent applicable to the health entity and its functions.

(3) The Ministry must, when performing any activity authorised or required under this Act, be guided by the health system principles—

(a) as far as reasonably practicable, having regard to all the circumstances, including any resource constraints; and

(b) to the extent applicable to the Ministry.

(4) The health system principles in **subsection (1)(b) and (c)** do not apply to Pharmac and the performance of its functions.

8 Transitional, savings, and related provisions

The transitional, savings, and related provisions set out in **Schedule 1** have effect according to their terms.

9 Act binds the Crown

This Act binds the Crown.

Part 2
Key roles and health documents

Subpart 1—Minister of Health

10 Overview of Minister's role

(1) The Minister's role in the New Zealand health system includes—

(a) issuing a Government Policy Statement and the following health strategies:

(i) New Zealand Health Strategy:

(ii) Hauora Māori Strategy:

(iii) Pacific Health Strategy:

(iv) Disability Health Strategy:

(b) approving the New Zealand Health Plan developed by Health New Zealand and the Māori Health Authority; and

(c) approving the New Zealand Health Charter and the Code of Consumer Participation; and

(d) establishing committees under this Act; and

(e) exercising intervention powers under **sections 55 to 57**.

(2) This section is intended as a guide only.

Subpart 2—Health New Zealand

11 Health New Zealand established

(1) Health New Zealand is established.

(2) Health New Zealand is a Crown agent within the meaning of section 10(1) of the Crown Entities Act 2004.

(3) The Crown Entities Act 2004 applies to Health New Zealand, except to the extent that this Act expressly provides otherwise.

12 Board of Health New Zealand

(1) The board of Health New Zealand consists of not fewer than 5, and not more than 8, members.

(2) The Minister must appoint the members of the board (other than the member referred to in **subsection (4)**) and the chairperson.

(3) When appointing members, the Minister must be satisfied that the board, collectively has knowledge of, and experience and expertise in relation to,—

(a) te Tiriti o Waitangi (the Treaty of Waitangi) and tikanga Māori; and

(b) the public funding and provision of services; and

(c) public sector governance and government processes; and

(d) financial management.

(4) The chairperson of the Māori Health Authority (or the nominated co-chairperson referred to in **section 22(3)**)—

(a) is, by virtue of holding that office, a member of the board of Health New Zealand with voting rights; and

(b) may delegate that membership to a deputy chairperson of the Māori Health Authority.

13 Objectives of Health New Zealand

The objectives of Health New Zealand are—

(a) to design, arrange, and deliver services to achieve the purpose of this Act in accordance with the health system principles; and

(b) to encourage and maintain community participation in health improvement and service planning; and

(c) to promote health and prevent, reduce, and delay ill-health, including by collaborating with other social sector agencies to address the determinants of health.

14 Functions of Health New Zealand

(1) The functions of Health New Zealand are to—

(a) jointly develop and implement a New Zealand Health Plan with the Māori Health Authority; and

(b) own and operate services; and

(c) provide or arrange for the provision of services at a national, regional, and local level; and

(d) develop and implement commissioning frameworks and models for the purpose of **paragraph (c)**; and

(e) set requirements and specifications for publicly funded services; and

(f) develop and implement locality plans; and

(g) undertake and promote public health initiatives, including commissioning services to deliver public health programmes specified by the Public Health Agency; and

(h) improve service delivery and outcomes at all levels within the health system; and

(i) collaborate with other providers of social services to improve health and wellbeing outcomes; and

(j) work with the Māori Health Authority when performing any function in **paragraphs (c) to (i)**; and

(k) contribute to key health documents in **subpart 5**; and

(l) engage with iwi-Māori partnership boards; and

(m) evaluate the delivery and performance of services provided or funded by Health New Zealand; and

(n) provide accessible and understandable information to the public on health system performance; and

(o) provide, or arrange for the provision of, services on behalf of the Crown or any Crown entity within the meaning of the Crown Entities Act 2004; and

(p) perform or exercise the functions, duties, and powers conferred or imposed on it by this Act or any other enactment; and

(q) perform any other functions relevant to its objectives that the responsible Minister directs in accordance with section 112 of the Crown Entities Act 2004.

(2) Health New Zealand must give effect to the GPS and the New Zealand Health Plan when performing its functions.

(3) In performing any of its functions in relation to the supply of pharmaceuticals, Health New Zealand must not act inconsistently with the pharmaceutical schedule.

15 Health New Zealand must provide information to iwi-Māori partnership boards

Health New Zealand must provide sufficient and timely information to iwi-Māori partnership boards to support them to achieve their purpose in **section 92**.

16 Additional collective duties of board of Health New Zealand

(1) The board must ensure that Health New Zealand—

(a) acts in a manner consistent with the GPS and the New Zealand Health Plan; and

(b) works collaboratively with the Māori Health Authority; and

(c) operates in a financially responsible manner and, for this purpose, endeavours to cover all its annual costs (including the cost of capital) from its net annual income; and

(d) maintains systems and processes to ensure Health New Zealand,—

(i) has the capacity and capability to perform its functions; and

(ii) when performing any function in relation to Māori, has the capacity and capability to understand te Tiriti o Waitangi (the Treaty of Waitangi), mātauranga Māori, and Māori perspectives of services.

(2) The duties of the board in **subsection (1)** are—

(a) in addition to its duties in sections 49 to 52 of the Crown Entities Act 2004; and

(b) collective duties owed to the Minister for the purposes of section 58 of the Crown Entities Act 2004.

Subpart 3—Māori Health Authority

17 Māori Health Authority established

(1) The Māori Health Authority is established.

(2) The Māori Health Authority is an independent statutory entity.

18 Objectives of Māori Health Authority

The objectives of the Māori Health Authority are to—

(a) ensure that planning and service delivery respond to the aspirations and needs of whānau, hapū, iwi, and Māori in general; and

(b) design and arrange services—

(i) to achieve the purpose of this Act in accordance with the health system principles; and

(ii) to achieve the best possible health outcomes for whānau, hapū, and Māori in general; and

(c) promote Māori health and prevent, reduce, and delay the onset of ill-health for Māori, including by collaborating with other social sector agencies to address the determinants of Māori health.

19 Functions of Māori Health Authority

(1) The functions of the Māori Health Authority are to—

(a) jointly develop and implement a New Zealand Health Plan with Health New Zealand; and

(b) own and operate services; and

(c) improve service delivery and outcomes for Māori at all levels of the health system; and

(d) collaborate with other providers of social services to improve health and wellbeing outcomes for Māori; and

(e) provide accessible and understandable information to Māori on health system performance; and

(f) commission kaupapa Māori services and other services developed for Māori in accordance with the New Zealand Health Plan; and

(g) review locality plans developed by Health New Zealand and participate in the processes set out in **sections 48 and 49**; and

(h) provide policy and strategy advice to the Minister on matters relevant to hauora Māori; and

(i) work with Health New Zealand when Health New Zealand performs any function in **section 14(c) to (i)**; and

(j) contribute to key health documents in **subpart 5**; and

(k) monitor the delivery of hauora Māori services by Health New Zealand; and

(l) monitor, in co-operation with the Ministry and Te Puni Kōkiri, the performance of the health system in relation to hauora Māori; and

(m) support and engage with iwi-Māori partnership boards in accordance with **section 21**; and

(n) design and deliver programmes for the purpose of improving the capability and capacity of Māori health providers and the Māori health workforce; and

(o) perform or exercise the functions, duties, and powers conferred or imposed on it by this Act or any other enactment; and

(p) perform any other functions relevant to its objectives that the responsible Minister directs in accordance with section 112 of the Crown Entities Act 2004.

(2) The Māori Health Authority must give effect to the GPS and the New Zealand Health Plan when performing its functions.

(3) The Māori Health Authority has all the powers necessary to perform its functions.

20 Engaging with and reporting to Māori

(1) The Māori Health Authority must—

(a) have systems in place for the purpose of—

(i) engaging with Māori in relation to their aspirations and needs for the health system; and

(ii) enabling the responses from that engagement to inform the performance of its functions; and

(b) engage with relevant Māori organisations when—

(i) jointly developing the New Zealand Health Plan with Health New Zealand; and

(ii) advising on the GPS and any health strategy; and

(iii) preparing its statement of intent and statement of performance expectations; and

(c) report back to Māori from time to time on how engagement under this section has informed the performance of its functions.

(2) In this section,—

Māori organisation includes (without limitation) iwi-Māori partnership boards, iwi and hapū authorities, rūnanga, trust boards, Māori health professionals' organisations, and representatives of whānau and hapū

relevant Māori organisation means a Māori organisation that the Māori Health Authority considers relevant for the purpose of the engagement.

21 Māori Health Authority to support and engage with iwi-Māori partnership boards

The Māori Health Authority must—

(a) take reasonable steps to support iwi-Māori partnership boards to achieve their purpose in **section 92**, including by—

(i) providing administrative, analytical, or financial support where needed; and

(ii) providing sufficient and timely information; and

(b) engaging with iwi-Māori partnership boards when determining priorities for kaupapa Māori investment.

22 Board of Māori Health Authority

(1) The board of the Māori Health Authority consists of not fewer than 5, and not more than 8, members.

(2) When appointing members, the Minister must be satisfied that the board, collectively, has knowledge of, and experience and expertise in relation to,—

(a) te Tiriti o Waitangi (the Treaty of Waitangi), tikanga Māori, and mātauranga Māori; and

(b) kaupapa Māori services; and

(c) cultural safety and responsiveness of services; and

(d) the public funding and provision of services; and

(e) public sector governance and government processes; and

(f) financial management.

(3) The Minister must appoint a chairperson or 2 co-chairpersons of the board. If co-chairpersons are appointed, the Minister must nominate a co-chairperson to be a member of the board of Health New Zealand.

(4) Sections 28 (other than section 28(1)(b)) and 29 of the Crown Entities Act 2004 apply to the appointment of members of the board of the Māori Health Authority, except that the Minister must consult the Hauora Māori advisory committee before appointing any member.

(5) Section 32(1)(a) and 32(2) to (4) of the Crown Entities Act 2004 applies to the term of office of members of the board.

23 Removal of members

(1) The Minister may at any time remove a member of the board of the Māori Health Authority from office if the Minister—

(a) considers that the removal is justified for any reason; and

(b) has consulted the Hauora Māori advisory committee and had regard to its views.

(2) The removal must be made by written notice to the member (with a copy to the Māori Health Authority).

(3) The notice must—

(a) state the date on which the removal takes effect which must not be earlier than the date on which the notice is received; and

(b) state the reasons for the removal.

(4) The Minister must notify the removal in the *Gazette* as soon as practicable after the notice is given.

24 Financial operations of Māori Health Authority

The board of the Māori Health Authority must ensure that the Māori Health Authority operates in a financially responsible manner and, for this purpose, endeavours to cover all its annual costs (including the cost of capital) from its net annual income.

25 Application of Crown Entities Act 2004 to Māori Health Authority

The following provisions of the Crown Entities Act 2004 apply, subject to this Act and with all necessary modifications, to the Māori Health Authority:

(a) sections 15, 17 to 35, and 41 to 78; and

(b) subpart 3 of Part 2 except section 98(1)(c); and

(c) Part 3 except sections 104 to 106 and 116; and

(d) Part 4; and

(e) Schedule 5 except clause 4.

26 Application of Public Service Act 2020 to Māori Health Authority

The following provisions of the Public Service Act 2020 apply to the Māori Health Authority:

(a) sections 12 and 13; and

(b) subpart 4 of Part 1; and

(c) Part 4.

27 Application of Public Records Act 2005

The Māori Health Authority is a public office for the purposes of the Public Records Act 2005.

Subpart 4—Disputes

28 Disputes between Health New Zealand and Māori Health Authority

(1) If Health New Zealand and the Māori Health Authority disagree on a matter that they are required under this Act to work together on, jointly develop, or agree,—

(a) either party may give written notice to the other party that they wish to resolve the dispute in accordance with this section; and

(b) as soon as practicable after a party has received written notice, the chief executives of each party must meet and use their best endeavours to resolve the dispute.

(2) The parties—

(a) must refer the dispute to the Minister if they have not resolved it within 20 working days after the date a party received written notice under **subsection (1)(a)**; or

(b) may refer the dispute to the Minister earlier if they agree.

(3) The Minister may determine the dispute or a process to resolve the dispute and, for that purpose, may require any party to provide information to the Minister.

(4) The parties must comply with the Minister's determination or the process determined by the Minister and its outcome.

Subpart 5—Key health documents

29 Overview of important health documents

(1) This subpart requires—

(a) the Minister to issue a Government Policy Statement that sets out the Government's priorities and objectives for the health system:

(b) the Minister to determine the following strategies for improving the health status of New Zealanders:

(i) New Zealand Health Strategy:

(ii) Hauora Māori Strategy:

(iii) Pacific Health Strategy:

(iv) Disability Health Strategy:

(c) Health New Zealand and the Māori Health Authority to develop a New Zealand Health Plan based on population health needs:

(d) the Minister to approve the New Zealand Health Plan:

(e) Health New Zealand and the Māori Health Authority to approve locality plans for localities:

(f) the Minister to determine a New Zealand Health Charter to guide health entities and their workers:

(g) the Minister to determine a Code of Consumer Participation to support consumer participation and enable the consumer to be voice to heard.

(2) This section is intended as a guide only.

Government Policy Statement on Health

30 GPS

(1) The Minister must issue a GPS at intervals of no more than 3 years apart.

(2) The purpose of the GPS is to—

(a) set priorities for the health system; and

(b) set clear parameters for the development of the New Zealand Health Plan.

(3) The GPS—

(a) must cover a period of at least 3 consecutive financial years; and

(b) expires on the close of the third consecutive financial year to which it applies.

(4) The Minister must issue the GPS before the start of the first financial year to which it applies.

(5) This Minister must issue the first GPS no later than 2 years after the commencement of this Act.

31 Preparation of GPS

When preparing a GPS, the Minister must—

(a) be satisfied that the GPS contributes to the purpose of this Act; and

(b) have regard to, but is not bound by, any health strategy; and

(c) consult with Health New Zealand and the Māori Health Authority and have regard to their views; and

(d) engage with organisations and individuals that the Minister considers appropriate.

32 Content of GPS

(1) The GPS must include the following:

(a) the Government's priorities and objectives for the health system:

(b) how the Government expects health entities to meet the Government's priorities and objectives for the health system:

(c) the Government's priorities in relation to Māori, which must include the following priorities:

(i) improving health outcomes for Māori; and

(ii) engaging with Māori:

(d) the Government's priorities for improving health outcomes for Pacific people, disabled people, rural communities, and other populations:

(e) a framework for regular monitoring of progress and reporting requirements.

(2) The GPS may include any other matters the Minister considers relevant.

(3) To avoid doubt, the GPS may not impose an obligation on any health entity to approve or decline funding for a particular product, service, or provider.

33 GPS must be made available

(1) As soon practicable after issuing a GPS, the Minister must present a copy of the GPS to the House of Representatives.

(2) The GPS must be made publicly available as soon as practicable after it is issued.

34 Status of GPS

(1) A GPS is not a direction for the purposes of Part 3 of the Crown Entities Act 2004.

(2) **Sections 30 to 35** do not limit other provisions relating to directions in the Crown Entities Act 2004.

35 Health entities must give effect to GPS

A health entity must give effect to the GPS to the extent it is relevant to its functions and subject to any applicable directions under section 103 of the Crown Entities Act 2004.

36 Amending GPS

(1) The Minister may amend the GPS at any time.

(2) **Sections 31 and 33** do not apply to an amendment to the GPS if the Minister considers the amendment is not significant.

Health strategies

37 New Zealand Health Strategy

(1) The Minister must prepare and determine a New Zealand Health Strategy.

(2) The purpose of the New Zealand Health Strategy is to provide a framework to guide the health system in protecting, promoting, and improving people's health and wellbeing.

(3) The New Zealand Health Strategy must—

(a) contain an assessment of the current state of health outcomes and health system performance; and

(b) contain an assessment of the medium and long-term trends and risks that will impact on health outcomes and health system performance in the next 5 to 10 years; and

(c) set out opportunities and priorities for improving the health system over at least the next 5 to 10 years, including workforce development.

(4) **Subsection (3)** does not limit what may be included in the New Zealand Health Strategy.

38 Hauora Māori Strategy

(1) The Minister must prepare and determine a Hauora Māori Strategy.

(2) The purpose of the Hauora Māori Strategy is to provide a framework to guide the health system in improving Māori health outcomes.

(3) The Hauora Māori Strategy must—

(a) contain an assessment of the current state of Māori health outcomes and the performance of the health system in relation to Māori; and

(b) contain an assessment of medium to long-term trends that will affect hauora Māori and health system performance; and

(c) set out priorities for services and health system improvements relating to hauora Māori, including workforce development.

(4) **Subsection (3)** does not limit what may be included in the Hauora Māori Strategy.

39 Pacific Health Strategy

(1) The Minister must prepare and determine a Pacific Health Strategy.

(2) The purpose of the Pacific Health Strategy is to provide a framework to guide the health system in improving Pacific health outcomes in New Zealand.

(3) The Pacific Health Strategy must—

(a) contain an assessment of the current state of Pacific health outcomes and the performance of the health system in relation to Pacific peoples; and

(b) contain an assessment of the medium and long-term trends that will affect Pacific health and health system performance; and

(c) set out priorities for services and health system improvements relating to Pacific health, including workforce development.

(4) **Subsection (3)** does not limit what may be included in the Pacific Health Strategy.

(5) In this section, **Pacific health** means the health of Pacific peoples.

40 Disability Health Strategy

(1) The Minister must prepare and determine a Disability Health Strategy.

(2) The purpose of the Disability Health Strategy is to provide a framework to guide the health system in improving health outcomes for disabled people.

(3) The Disability Health Strategy must—

(a) contain an assessment of the current state of health outcomes for disabled people and the performance of the health system in relation to disabled people; and

(b) contain an assessment of the medium and long-term trends that will affect the health of disabled people and health system performance; and

(c) set out priorities for services and health system improvements relating to the health of disabled people, including workforce development.

(4) **Subsection (3)** does not limit what may be included in the Disability Health Strategy.

41 Process for making health strategy

(1) When preparing a health strategy, the Minister must—

(a) have regard to any advice from the Māori Health Authority; and

(b) consult health entities or groups that the Minister considers are reasonably likely to be affected by the health strategy.

(2) The Minister must present the health strategy to the House of Representatives as soon practicable after it has been made.

(3) The health strategy must be made publicly available as soon as practicable after it is made.

42 Review and progress of health strategy

The Minister must—

(a) regularly monitor and review all health strategies; and

(b) assess how the health system has performed against the health strategies.

43 Health entities must have regard to health strategies

A health entity must have regard to all health strategies—

(a) when exercising its powers or performing its functions or duties; and

(b) to the extent that the health strategy is relevant to those powers, functions, or duties.

New Zealand Health Plan

44 New Zealand Health Plan

(1) Health New Zealand and the Māori Health Authority must jointly develop a New Zealand Health Plan.

(2) The purpose of the plan is to provide a 3–year costed plan for the delivery of publicly-funded services by Health New Zealand and the Māori Health Authority.

(3) The plan must give effect to the GPS.

(4) In developing the plan, Health New Zealand and the Māori Health Authority must also take into account—

(a) the functions and services of other health entities and government agencies that contribute to improving health outcomes; and

(b) the role of the Cancer Control Agency, Health and Disability Commission, Health Research Council, Mental Health and Wellbeing Commission, and Ministry (including the Public Health Agency) within the health system.

45 Content of New Zealand Health Plan

The New Zealand Health Plan must—

(a) contain an assessment of population health needs; and

(b) identify—

(i) desired improvements in health outcomes (**desired improvements**); and

(ii) priorities for the desired improvements; and

(c) describe how the health system will deliver service and investment changes to achieve the desired improvements, including—

(i) how Health New Zealand and the Māori Health Authority will provide and commission services to achieve the desired improvements; and

(ii) how other health entities will contribute to achieving the desired improvements; and

(d) describe how the matters referred to in **section 44(4)** have been taken into account; and

(e) describe how other government agencies will contribute to achieving the desired improvements; and

(f) set out—

(i) key services and activities to be delivered; and

(ii) key performance measures; and

(g) set out how Health New Zealand and the Māori Health Authority—

(i) will achieve the purpose of this Act; and

(ii) will engage with Māori and protect Māori interests and aspirations; and

(iii) have been guided by the health system principles in the development and content of the New Zealand Health Plan; and

(h) set out any other matters the Minister directs.

46 Reports

(1) Health New Zealand and the Māori Health Authority must jointly prepare an annual performance report against the New Zealand Health Plan.

(2) The report must, soon as practicable after it is made,—

(a) be presented to the House of Representatives; and

(b) be made publicly available.

47 Process

(1) In preparing the New Zealand Health Plan, Health New Zealand and the Māori Health Authority must engage with—

(a) the Ministry; and

(b) other health entities; and

(c) individuals and organisations that Health New Zealand and the Māori Health Authority consider appropriate.

(2) The plan is made when the Minister approves it.

(3) **Subsection (1)(a) to (c)** does not apply to any amendments to the plan that do not have a significant impact on consumers or providers of services (other than the boards of Health New Zealand and the Māori Health Authority).

(4) The plan must, as soon as practicable after it is made,—

(a) be presented to the House of Representatives; and

(b) be made publicly available.

Localities and locality plans

48 Determination of localities

(1) Health New Zealand must determine, with the agreement of the Māori Health Authority, geographically defined areas (**localities**) for the purpose of arranging services.

(2) Health New Zealand must ensure that—

(a) all of New Zealand is covered by a locality; and

(b) the boundary of a locality is consistent with any regional arrangement specified in regulations made under **section 97**; and

(c) a list of all localities (including their geographical areas) is made publicly available.

(3) Health New Zealand may, with the agreement of the Māori Health Authority, amend the number or boundaries of any localities at any time, as long as the requirements in **subsection (2)** are met.

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.

(3) In developing a locality plan for a locality, Health New Zealand must—

(a) consult consumers or communities within the locality; and

(b) consult social sector agencies and other entities that contribute to relevant population outcomes within the locality; and

(c) consult—

(i) the Māori Health Authority; and

(ii) iwi-Māori partnership boards for the area covered by the plan; and

(iii) any other individual or group that Health New Zealand considers appropriate.

(4) A locality plan is made—

(a) when it is agreed to by Health New Zealand and the Māori Health Authority; or

(b) if **section 28** applies, when it is made in accordance with **section 28(4)**.

New Zealand Health Charter

50 Minister must determine New Zealand Health Charter

(1) The Minister must determine a New Zealand Health Charter.

(2) The purpose of the charter is provide common values, principles, and behaviours to guide health entities and their workers.

(3) To avoid doubt, nothing in this section affects the role of responsible authorities under the Health Practitioners Competence Assurance Act 2003 in setting and enforcing minimum standards for health practitioners.

51 Health entities must have regard to charter

A health entity must—

(a) have regard to the New Zealand Health Charter when planning for and contracting services; and

(b) report annually on how it has given effect to the charter.

52 Making of charter

(1) In preparing the New Zealand Health Charter, the Minister must engage with—

(a) health entities; and

(b) organisations that, in the Minister's opinion, are representative of the interests of workers who work for health entities; and

(c) Māori health professional organisations.

(2) The charter is made when the Minister approves it.

(3) The charter must, as soon as practicable after it is made,—

(a) be presented to the House of Representatives; and

(b) be made publicly available.

Consumer participation

53 Code of Consumer Participation

(1) The HQSC must develop a Code of Consumer Participation.

(2) The code must contain principles for the purpose of supporting consumer participation and enabling the consumer voice to be heard.

(3) The code is made when the Minister approves it.

(4) The code must, as soon as practicable after it is made,—

(a) be presented to the House of Representatives; and

(b) be made publicly available.

54 Health entities must act in accordance with Code of Consumer Participation

A health entity must act in accordance with the Code of Consumer Participation when engaging with consumers.

Subpart 6—Ministerial powers

55 Minister may appoint Crown observers

(1) The Minister may make an appointment under this section if—

(a) the Minister considers it desirable for the purpose of assisting in improving the performance of Health New Zealand or the Māori Health Authority; and

(b) in the case of an appointment to the Māori Health Authority, the Hauora Māori advisory committee agrees.

(2) The Minister may—

(a) appoint 1 or more persons to be a Crown observer of Health New Zealand or the Māori Health Authority (as the case may be); and

(b) require the Crown observer to attend—

(i) any board meeting or board committee meeting of the health entity; or

(ii) any executive level meeting of the health entity at a national or regional level.

(3) The person in charge of a meeting described in **subsection (2)(b)** must—

(a) permit the Crown observer to attend; and

(b) provide the Crown observer with copies of all notices, documents, and other information that are provided to those attending the meeting.

(4) The Crown observer's functions are to—

(a) observe the meeting's decisions and decision-making processes; and

(b) assist those at the meeting in understanding the policies and wishes of the Government so that they can be appropriately reflected in decisions of the meeting; and

(c) advise the Minister on any matter relating to the health entity or the board, or its performance.

(5) The appointment of a person as a Crown observer is on terms and conditions agreed between the Minister and the person.

(6) A Crown observer may provide to the Minister any information that the Crown observer obtains in the course of acting as such.

(7) **Subsection (6)** is subject to the Privacy Act 2020.

Compare: 2000 No 91 s 30

56 Minister may dismiss board or appoint commissioner

(1) If the Minister is seriously dissatisfied with the performance of the board of Health New Zealand or the Māori Health Authority, the Minister may by written notice, dismiss all members of the board.

(2) The Minister may, by written notice, appoint a commissioner to replace the board of Health New Zealand or the Māori Health Authority if,—

(a) all the members of the board are removed from office under **subsection (1)** or the Crown Entities Act 2004; and

(b) in the case of an appointment replacing the board of the Māori Health Authority, the Hauora Māori advisory committee agrees.

(3) A commissioner has all the functions, duties, powers, and protections of the board and of a member of the board.

(4) A commissioner may appoint, on any terms and conditions that may be agreed, up to 3 deputy commissioners, each of whom must be a person who would be eligible to be appointed by the Minister to the board.

(5) The Minister may at any time, by written notice, dismiss a commissioner from office.

(6) A commissioner may at any time, by written notice, dismiss a deputy commissioner from office with the agreement of the Minister.

(7) All the provisions of this Act and the Crown Entities Act 2004 that apply to appointed members of a board apply, with any necessary modifications, to a commissioner and a deputy commissioner.

(8) To avoid doubt, a member of the board of Health New Zealand referred to in **section 12(4)(a)** is a member of that board for the purpose of **subsection (1)**.

Compare: 2000 No 91 s 31

57 Improvement plan

(1) If the Minister believes on reasonable grounds it is necessary to improve the performance of a health entity, the Minister may by written notice to the health entity,—

(a) identify any areas within the functions of the health entity that require improvement; and

(b) explain why the Minister believes those areas require improvement; and

(c) require the health entity to prepare an improvement plan for the Minister's approval.

(2) The Minister may approve the plan if satisfied that the plan addresses the areas identified in the notice.

(3) The health entity must implement the improvement plan within any time-frame specified in the plan.

(4) The health entity must make the improvement plan publicly available as soon as practicable after it is approved.

58 Provision of information

(1) The Minister of Finance may, by written notice, require a health entity to—

(a) provide economic or financial forecasts or other economic or financial information relating to the health entity or any or all of its subsidiaries specified in the notice; and

(b) provide that information to the Minister or any person or class of person specified in the notice.

(2) A health entity must comply with a requirement under **subsection (1)**.

(3) No requirement under this section may require the supply of any information that would breach the privacy of any natural person or deceased natural person, unless the person (or a representative of the deceased person) has consented to the supply.

(4) **Subsection (1)** does not limit sections 133 and 134 of the Crown Entities Act 2004.

(5) **Subsection (2)** applies despite section 134 of the Crown Entities Act 2004.

Compare: 44

59 Restrictions on directions under section 103 of Crown Entities Act 2004

(1) No direction may be given to the Māori Health Authority under section 103 of the Crown Entities Act 2004 unless it relates to improving equity of access and outcomes for Māori.

(2) No direction may be given to Pharmac under section 103 of the Crown Entities Act 2004 that would—

(a) require Pharmac to purchase a pharmaceutical from a particular source or at a particular price; or

(b) provide any pharmaceutical or pharmaceutical subsidy or other benefit to a named individual.

(3) No direction may be given to NZBOS under section 103 of the Crown Entities Act 2004 unless it concerns—

(a) NZBOS's role in providing oversight and clinical governance of the organ donation system and in providing support to the transplantation system; or

(b) protecting the gift status, donation, collection, processing, and supply of blood or controlled human substances (as defined in section 55 of the Human Tissue Act 2008); or

(c) withdrawal of contaminated blood or contaminated controlled human substances from supply.

Part 3
Other roles

Subpart 1—Pharmac

60 Pharmac

(1) There continues be a Pharmaceutical Management Agency (**Pharmac**).

(2) Pharmac is the same organisation that, immediately before the commencement of this section, was known as Pharmac.

(3) Pharmac is a Crown entity for the purposes of section 7 of the Crown Entities Act 2004.

(4) The Crown Entities Act 2004 applies to Pharmac except to the extent that this Act expressly provides otherwise.

61 Objectives of Pharmac

(1) The objectives of Pharmac are—

(a) to secure for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided; and

(b) any other objectives it is given by or under any enactment, or authorised to perform by the Minister by written notice to the board of Pharmac after consultation with it.

(2) In this section, **eligible people** means people belonging to a class specified in regulations made under **section 97** as being eligible to receive services funded under this Act.

62 Functions of Pharmac

(1) The functions of Pharmac are—

(a) to maintain and manage a pharmaceutical schedule that applies consistently throughout New Zealand, including determining eligibility and criteria for the provision of subsidies; and

(b) to manage incidental matters arising out of **paragraph (a)**, including in exceptional circumstances providing for subsidies for the supply of pharmaceuticals not on the pharmaceutical schedule; and

(c) to engage as it sees fit, but within its operational budget, in research to meet the objectives set out in **section 61(1)(a)**; and

(d) to promote the responsible use of pharmaceuticals; and

(e) to perform any other functions it is for the time being given under any enactment, or authorised to perform by the Minister by written notice to the board of Pharmac after consultation with it.

(2) Pharmac must perform its functions within the amount of funding provided to it and in accordance with its statement of intent (including the statement of forecast service performance) and (subject to **section 59**) any directions given under the Crown Entities Act 2004.

63 Pharmac to consult in implementing objectives and performing functions

In performing its functions, Pharmac must, when it considers it appropriate to do so,—

(a) consult on matters that relate to the management of pharmaceutical expenditure with any sections of the public, groups, or individuals that,

in the view of Pharmac, may be affected by decisions on those matters; and

(b) take measures to inform the public, groups, and individuals of Pharmac's decisions concerning the pharmaceutical schedule.

64 Board of Pharmac to ensure advisory committees

(1) The board of Pharmac must ensure that there are the following advisory committees under clause 14(1)(a) of Schedule 5 of the Crown Entities Act 2004:

(a) a pharmacology and therapeutics advisory committee to provide objective advice to Pharmac on pharmaceuticals and their benefits:

(b) a consumer advisory committee to provide input from a consumer or patient point of view.

(2) Despite clause 14(1)(a) of Schedule 5 of the Crown Entities Act 2004, the members of the pharmacology and therapeutics advisory committee are appointed by the Director-General in consultation with the board of Pharmac.

65 Publication of notices

The Minister must, as soon as practicable after giving a notice under **section 61(1)(b) or 62(1)(e)**, publish in the *Gazette*, and present to the House of Representatives, a copy of the notice.

66 Membership of board of Pharmac

The board of Pharmac consists of up to 6 members appointed under section 28 of the Crown Entities Act 2004.

67 Exemption from Part 2 of Commerce Act 1986

(1) In this section, unless the context otherwise requires,—

agreement—

(a) includes any agreement, arrangement, contract, covenant, deed, or understanding, whether oral or written, whether express or implied, and whether or not enforceable at law; and

(b) without limiting the generality of **paragraph (a)**, includes any contract of service and any agreement, arrangement, contract, covenant, or deed, creating or evidencing a trust

pharmaceuticals means substances or things that are medicines, therapeutic medical devices, or products or things related to pharmaceuticals.

(2) Nothing in Part 2 of the Commerce Act 1986 applies to—

(a) any agreement to which Pharmac is a party and that relates to pharmaceuticals for which full or part-payments may be made from money appropriated under the Public Finance Act 1989; or

(b) any act, matter, or thing, done by any person for the purposes of entering into such an agreement; or

(c) any act, matter, or thing done by any person to give effect to such an agreement.

Subpart 2—New Zealand Blood and Organ Service

68 NZBOS

(1) There continues to be a New Zealand Blood and Organ Service (**NZBOS**).

(2) NZBOS is the same organisation that, immediately before the commencement of this section, was known as NZBOS.

(3) NZBOS is a Crown entity for the purposes of section 7 of the Crown Entities Act 2004.

(4) The Crown Entities Act 2004 applies to NZBOS except to the extent that this Act provides expressly otherwise.

69 Functions of NZBOS

(1) The functions of NZBOS are—

(a) to manage the donation, collection, processing, and supply of blood, controlled human substances, and related or incidental matters; and

(b) to provide oversight and clinical governance of the organ donation system, to provide support to the transplantation system, and manage any related or incidental matters; and

(c) if it is an appointed entity, to perform the functions for which it is for the time being responsible under 63 of the Human Tissue Act 2008; and

(d) to perform any other functions it is for the time being given by or under any enactment, or authorised to perform by the Minister by written notice to the board of NZBOS after consultation with it.

(2) NZBOS must perform its functions in **subsection (1)(a) and (b)** in accordance with its statement of intent (including the statement of forecast service performance) and (subject to **section 59**) any directions given under the Crown Entities Act 2004.

(3) The Minister must, as soon as practicable after giving a notice under **subsection (1)(d)**, publish in the *Gazette*, and present to the House of Representatives, a copy of the notice.

(4) In this section, **appointed entity**, **blood**, and **controlled human substance** have the same meaning as in section 55 of the Human Tissue Act 2008.

70 Membership of board

The board of NZBOS consists of up to 7 members appointed under section 28 of the Crown Entities Act 2004.

Subpart 3—Health Quality and Safety Commission

71 Health Quality and Safety Commission

(1) There continues to be a Health Quality and Safety Commission (**HQSC**).

(2) HQSC is the same organisation that, immediately before the commencement of this section, was known as HQSC.

(3) HQSC is a Crown entity for the purposes of section 7 of the Crown Entities Act 2004.

(4) The Crown Entities Act 2004 applies to HQSC except to the extent that this Act expressly provides otherwise.

72 Objectives of HQSC

The objectives of HQSC are to lead and co-ordinate work across the health system for the purposes of—

(a) monitoring and improving the quality and safety of services; and

(b) helping providers to improve the quality and safety of services.

73 Functions of HQSC

(1) The functions of HQSC are—

(a) to advise the Minister on how quality and safety in services may be improved; and

(b) to advise the Minister on any matter relating to—

(i) health epidemiology and quality assurance; or

(ii) mortality; and

(c) to determine quality and safety indicators (such as serious and sentinel events) for use in measuring the quality and safety of services; and

(d) to provide public reports on the quality and safety of services as measured against—

(i) the quality and safety indicators; and

(ii) any other information that HQSC considers relevant for the purpose of the report; and

(e) to promote and support better quality and safety in services; and

(f) to disseminate information about the quality and safety of services; and

(g) to support the health system to engage with consumers and whānau for the purpose of ensuring that their perspectives are reflected in the design, delivery, and evaluation of services; and

(h) to prepare a Code of Consumer Participation for approval by the Minister; and

(i) to perform any other function that—

(i) relates to the quality and safety of services; and

(ii) HQSC is for the time being authorised to perform by the Minister by written notice to HQSC after consultation with it.

(2) In performing its functions, HQSC must, to the extent it considers appropriate, work collaboratively with—

(a) the Ministry of Health; and

(b) the Health and Disability Commissioner; and

(c) the Māori Health Authority; and

(d) providers; and

(e) any groups representing the interests of consumers of services; and

(f) any other organisations, groups, or individuals that HQSC considers have an interest in, or will be affected by, its work.

(3) The Minister must, as soon as practicable after giving a notice to HQSC under **subsection (1)(i)(ii)**, publish in the *Gazette*, and present to the House of Representatives, a copy of the notice.

74 Membership of board of HQSC

The board of HQSC consists of at least 7 members appointed under section 28 of the Crown Entities Act 2004.

75 HQSC may appoint mortality review committees

(1) HQSC may appoint 1 or more committees to carry out any of the following functions that HQSC specifies by notice to the committee:

(a) to review and report to HQSC on specified classes of deaths of persons, or deaths of persons of specified classes, with a view to reducing the numbers of deaths of those classes or persons, and to continuous quality improvement through the promotion of ongoing quality assurance programmes:

(b) to advise on any other matters related to mortality that HQSC specifies in the notice.

(2) A committee appointed under **subsection (1)** (a **mortality review committee**) must develop strategic plans and methodologies that—

(a) are designed to reduce morbidity and mortality; and

(b) are relevant to the committee's functions.

(3) HQSC—

(a) must, at least annually, provide the Minister with a report on the progress of mortality review committees; and

(b) must include each such report in HQSC's next annual report.

(4) The provisions of **Schedule 4** apply in relation to a mortality review committee.

(5) Every person who fails, without reasonable excuse, to comply with a requirement imposed under **Schedule 4** by the chairperson of a mortality review committee commits an offence and is liable on conviction to a fine not exceeding $10,000.

(6) Every person who discloses information contrary to **Schedule 4** commits an offence and is liable on conviction to a fine not exceeding $10,000.

(7) Any member of a registered occupational profession who commits an offence under **subsection (5) or (6)** is liable to any disciplinary proceedings of that profession in respect of the offence, whether or not they are fined under that subsection.

Subpart 4—Provisions that apply to Pharmac, NZBOS, and HQSC

76 Organisation defined

In this subpart, **organisation** means each of the following organisations:

(a) Pharmac:

(b) NZBOS:

(c) HQSC.

77 Responsibility to operate in financially responsible manner

(1) Every organisation must operate in a financially responsible manner and for this purpose must endeavour to cover all its annual costs (including the cost of capital) from its net annual income.

(2) **Subsection (1)** does not apply to HQSC in respect of costs, which are to be met by the Ministry of Health in a financially responsible manner that allows HQSC to carry out its functions to a high standard.

(3) This section does not limit section 51 of the Crown Entities Act 2004.

78 Delegations policy

(1) Every board of an organisation must,—

(a) have a policy for the exercise of its powers of delegation under section 73 of the Crown Entities Act 2004 (**delegations policy**); and

(b) keep the policy under review and update the policy as it considers appropriate; and

(c) make the policy publicly available.

(2) A delegations policy—

(a) comes into force when the Minister approves it; and

(b) is subject to any conditions the Minister specifies in the approval.

(3) When a delegations policy is in force, every exercise by the board of a power of delegation under section 73 of the Crown Entities Act 2004 must comply with that policy.

79 Employees

(1) The terms and conditions of employment of a chief executive appointed by an organisation are determined by agreement between the board of the organisation and the chief executive, but the board must not finalise those terms and conditions, or agree to any amendments to any or all of those terms and conditions once they have been finalised, without first obtaining the consent of the Public Service Commissioner.

(2) The individual for the time being acting in the position of chief executive of an organisation may enter into a collective agreement on behalf of the organisation with any or all employees of the organisation, except that that individual must not finalise any such collective agreement without first consulting the Director-General on the terms and conditions of any such collective agreement.

(3) The Governor-General may, by Order in Council, exempt any organisation, or any organisation specified in the order, from the requirement to consult in **subsection (2)**.

(4) This section applies despite section 117(2) to (3) of the Crown Entities Act 2004, but section 117(1) of that Act applies to a chief executive of an organisation.

(5) Despite section 116(2) of the Crown Entities Act 2004, the Governor-General may not make an Order in Council under section 116(1) of that Act in relation to an organisation.

(6) An Order in Council made under this section is secondary legislation (*see* Part 3 of the Legislation Act 2019 for publication requirements).

80 Public Records Act 2005 to apply

An organisation (other than NZBOS) is a public office for the purposes of the Public Records Act 2005.

81 Committees

In making appointments to a committee of a board of an organisation, the board must endeavour, where appropriate, to ensure representation of Māori on the committee.

Subpart 5—Committees

Ministerial committees

82 Ministerial committees

(1) The Minister may by written notice—

(a) establish any committee (a **ministerial committee**) that the Minister considers necessary or desirable for any purpose relating to this Act or its administration; and

(b) appoint any person to be a member or chairperson of the committee; and

(c) terminate the committee or the appointment of a member or chairperson of the committee.

(2) A ministerial committee has the functions that the Minister determines by written notice to the committee.

(3) A ministerial committee—

(a) consists of such members as the Minister determines; and

(b) may, subject to any written directions that the Minister gives to the committee, regulate its procedure in any manner that the committee thinks fit.

(4) Each member of a ministerial committee is appointed on any terms and conditions (including terms and conditions as to remuneration and travelling allowances and expenses) that the Minister determines by written notice to the member.

(5) Nothing in this subpart limits any powers that the Minister has under any other enactment or rule of law.

83 Information about ministerial committees to be made public

(1) As soon as practicable—

(a) after giving a notice establishing a ministerial committee, the Minister must present to the House of Representatives a copy of the notice together with the following information:

(i) the name of the committee; and

(ii) the number of members of the committee:

(b) after giving a notice appointing any person to be a member or chairperson of a ministerial committee, the Minister must present to the House of Representatives a copy of the notice together with the following information:

(i) the name of the chairperson of the committee; and

(ii) the names of the members of that committee.

(2) As soon as practicable after giving a notice terminating any ministerial committee, the Minister must present to the House of Representatives a copy of the notice together with the following information:

(a) the name of the committee terminated; and

(b) the reasons for the termination of the committee.

(3) As soon as practicable after giving a notice under **section 82(2)** determining a function of a ministerial committee, the Minister must present to the House of Representatives a copy of the notice together with the following information:

(a) the functions of the committee; and

(b) any other terms of reference or directions (other than directions as to procedure).

(4) As soon as practicable after giving, under **section 82(3)(b)**, a written direction as to the procedure of a ministerial committee, the Minister must present to the House of Representatives a copy of the direction.

(5) In every annual report of the Ministry of Health, the Ministry must—

(a) give the following information in respect of every ministerial committee:

(i) the name of the committee:

(ii) the name of the chairperson of the committee:

(iii) the name of every member of the committee; and

(b) indicate whether there is a ministerial committee that has not reported to the Minister in the year to which the report relates.

Hauora Māori advisory committee

84 Hauora Māori advisory committee

(1) The Minister must establish a Hauora Māori advisory committee.

(2) The function of the committee is—

(a) to provide advice to the Minister on the matters specified in **subsection (3)**; and

(b) to advise the Minister for the purposes of **sections 55 and 56**; and

(c) to provide any other advice as the Minister requests.

(3) The Minister must seek and consider the committee's advice before exercising any power to—

(a) appoint or remove members of the Māori Health Authority Board; and

(b) require the Māori Health Authority to develop an improvement plan; and

(c) issue letters of expectation to the Māori Health Authority; and

(d) issue directions to the Māori Health Authority; and

(e) require amendments to the Māori Health Authority's Statement of Intent or Statement of Performance Expectations.

(4) **Section 82** applies to the committee and the appointment of its members with all necessary modifications.

National advisory committee on health services ethics

85 National advisory committee on health services ethics

(1) The Minister must, by written notice, appoint a national advisory committee for the purpose of obtaining advice on ethical issues of national significance in respect of any health and disability matters (including research and services).

(2) The committee must determine nationally consistent ethical standards across the health system and provide scrutiny for national health research and services.

(3) For the purpose of obtaining advice on specific ethical issues of national, regional, or public significance in respect of any health and disability matters, the Minister may, by written notice, appoint any 1 or more of the following committees:

(a) 1 or more ministerial committees:

(b) the ethics committee of the Health Research Council established under section 24 of the Health Research Council Act 1990—

to consider matters specified by the Minister and to report to the Minister or a person specified by the Minister.

(4) Before a committee appointed under **subsection (1) or (3)** gives advice, the committee must consult with any members of the public, persons involved in the funding or provision of services, and other persons that the committee considers appropriate.

(5) As soon as practicable after giving a notice under **subsection (1) or (3)**, the Minister must present a copy of the notice to the House of Representatives.

(6) A committee appointed under this section must, at least once a year, deliver to the Minister a report setting out its activities and summarising its advice on the matters referred to it under this section.

(7) As soon as practicable after receiving a report under **subsection (6)**, the Minister must present a copy of the report to the House of Representatives.

Expert advisory committee on public health

86 Expert advisory committee on public health

(1) The Minister must establish an expert advisory committee on public health.

(2) The purpose of the committee is to provide independent advice to the Minister, the Public Health Agency, and Health New Zealand on the following matters:

(a) public health issues, including factors underlying the health of people, whānau, and communities:

(b) the promotion of public health:

(c) any other matters that the Minister or the Public Health Agency specifies by notice to the committee.

(3) The committee—

(a) consists of such members as the Minister determines; and

(b) may, subject to any written directions that the Minister gives to the committee, regulate its procedure in any manner that the committee thinks fit.

(4) Each member of a committee is appointed on any terms and conditions (including terms and conditions as to remuneration and travelling allowances and expenses) that the Minister determines by written notice to the member.

Subpart 6—Iwi-Māori partnership boards

87 Purpose of iwi-Māori partnership boards

The purpose of iwi-Māori partnership boards is to represent local Māori perspectives on—

(a) the needs and aspirations of Māori in relation to hauora Māori outcomes; and

(b) how the health system is performing in relation to those needs and aspiration; and

(c) the design and delivery of services and public health interventions within localities.

88 Recognition of iwi-Māori partnership boards

(1) The criteria for recognition of an organisation as an iwi-Māori partnership board are as follows:

(a) the boundaries of the area covered by the organisation (the **area**) do not overlap with the boundaries of any area covered by any iwi-Māori partnership board; and

(b) all iwi within the area have been given an opportunity to nominate a member to the organisation; and

(c) reasonable steps have been taken to provide for representation from—

(i) the wider Māori community within the area (regardless of whether they are affiliated with an iwi within the area); and

(ii) hauora Māori experts.

(2) The membership of an iwi-Māori partnership board—

(a) must be determined by the board after it has complied with **subsection (1)(b) and (c)**; and

(b) may varied by the board in the same way.

(3) If an organisation wishes to be recognised as an iwi-Māori partnership board,—

(a) it must notify the Māori Health Authority; and

(b) the Māori Health Authority must, if satisfied that the criteria in **subsection (1)** have been met, advise the Minister accordingly; and

(c) the Minister must recommend the making of an Order in Council under **subsection (5)(a)**.

(4) If 2 or more iwi-Māori partnership boards agree to vary or merge their boundaries,—

(a) they must notify the Māori Health Authority; and

(b) the Māori Health Authority must, if satisfied that the criteria in **subsection (1)** have been met, advise the Minister accordingly.

(5) The Governor-General may, by Order in Council, on the recommendation of the Minister made in accordance with **subsection (6)**, amend **Schedule 3** for the purpose of—

(a) recognising an organisation as an iwi-Māori partnership board; and

(b) giving effect to an agreement to a variation or merger referred to in **subsection (4)**; and

(c) making any minor or consequential changes.

(6) The Minister may recommend the making of an Order in Council under **subsection (5)** only on the advice of the Māori Health Authority.

(7) An iwi-Māori partnership board may determine its own procedures.

(8) An organisation listed in column 1 of **Schedule 3** is recognised as the iwi-Māori partnership board for the corresponding area described in column 2 of **Schedule 3**.

(9) An Order in Council made under this section is secondary legislation (*see* Part 3 of the Legislation Act 2019 for publication requirements).

Part 4
General

Subpart 1—Powers in relation to service commissioning

89 Crown funding agreements

(1) The Minister may, on behalf of the Crown,—

(a) negotiate and enter into a Crown funding agreement containing any terms and conditions that may be agreed; and

(b) negotiate and enter into an agreement that amends a Crown funding agreement; and

(c) monitor performance under a Crown funding agreement.

(2) Nothing in this section limits any enactment or any powers that the Minister or the Crown has under any enactment or rule of law.

(3) The Ministry may exercise the Minister's powers under **subsection (1)** on the Minister's behalf except to the extent that the Minister determines by written notice.

(4) As soon as practicable after giving a notice under **subsection (3)**, the Minister must publish a copy of the notice in the *Gazette.*

(5) In this section, **monitor** in relation to a Crown funding agreement,—

(a) means to analyse on the basis of information provided under any relevant agreement and any other relevant substantiated information; and

(b) includes assessing the timeliness of the provision of information required to be provided under any agreement.

90 Arrangements relating to payments

(1) The Crown, Health New Zealand, or the Māori Health Authority may, subject to **section 91**, give notice (**notice**) of the terms and conditions (**terms and conditions**) on which it will make payment to any person or persons.

(2) A person who accepts the payment referred to in the notice is deemed to accept the terms and conditions.

(3) Compliance by the person with the terms and conditions may be enforced by the Crown or health entity (as the case may be) as if the person had signed a deed under which the person agreed to the terms and conditions.

(4) The terms and conditions, unless the notice expressly provides otherwise, are deemed to include a provision to the effect that 12 weeks' notice must be given of any amendment or revocation of the terms and conditions.

(5) The notice (including any amendment or revocation) must be published in the *Gazette* before it takes effect.

(6) The notice (including any amendment or revocation) must, soon as practicable after it is made,—

(a) be presented by the Minister to the House of Representatives; and

(b) be made publicly available.

(7) No notice may be issued under this section that would bind Pharmac or NZBOS.

91 Restrictions on notices given under section 90

(1) A notice under **section 90** must not be given without the written approval of the Minister if it—

(a) relates to services for which a notice has not been issued before; or

(b) sets terms and conditions in respect of particular services that depart from terms and conditions set out in an existing notice in respect of the same or substantially the same services; or

(c) differentiates between persons or classes of person accepting payment under **section 90**.

(2) The Minister may approve the notice subject to any conditions the Minister specifies.

(3) Any notice under **section 90** that departs from an existing notice in the manner referred to in **subsection (1)(b)** or differentiates in the manner referred to in **subsection (1)(c)** must include a statement of the reasons for the departure or differentiation.

(4) In this section, **existing notice** means a notice issued under **section 90** that is for the time being in force.

(5) The Minister must present to the House of Representatives a copy of any approval given under this section.

Compare: 89

Subpart 2—Provisions that apply to health entities

92 Accountability documents

(1) A health entity must ensure that its accountability documents comply with any regulations made under **section 97(1)(e)**.

(2) For the purpose of this section, **accountability document** means statements of intent, annual financial statements, and annual reports of a health entity under the Crown Entities Act 2004.

93 Director-General may require information from health entities

(1) For the purpose of monitoring the performance of any health entity or the health system in general, the Director-General may in writing—

(a) request from a health entity, information in relation to any matter; and

(b) specify a time frame by which the health entity must comply with the request.

(2) The health entity must comply with the request, and if a time frame is specified, within that time frame.

(3) The Director-General must not request under this section any personal health information of any identifiable person.

94 Health entities must provide information

A health entity must comply with any requirement specified in regulations made under **section 97** to provide information.

95 Minister's approval required for health entity's dealings with land

(1) A health entity must not sell, exchange, mortgage, or charge land without the Minister's prior written approval.

(2) A health entity must not grant a lease or licence for a term of more than 5 years over land without the Minister's prior written approval.

(3) For the purposes of **subsection (2)**, the term of a lease or licence includes any period (or, if the lease or licence provides for more than 1 such period, the total period) for which any person is entitled to have the lease or licence renewed.

(4) Any approval under this section may be subject to any conditions the Minister specifies, and may be given in respect of any land of a class the Minister specifies.

(5) To avoid doubt, the matters to which the Minister may have regard in giving an approval under **subsection (2)** in relation to any land include the question of the application to the land of clause 3 of Schedule 1 of the Health Sector (Transfers) Act 1993.

(6) This section applies despite sections 16 and 17 of the Crown Entities Act 2004.

(7) In this section, **health entity** includes a Crown entity subsidiary of a health entity.

Subpart 3—Secondary legislation

96 Levies for alcohol-related purposes

(1) Levies may be imposed for the purpose of enabling the Ministry to recover costs it incurs—

(a) in addressing alcohol-related harm; and

(b) in its other alcohol-related activities.

(2) **Schedules 5 and 6** apply for the purpose of this section.

97 Regulations

(1) The Governor-General may, by Order in Council, on the recommendation of the Minister, make regulations—

Regional arrangements

(a) specifying regional arrangements—

(i) through which Health New Zealand and the Māori Health Authority must provide and arrange services; and

(ii) which must be maintained by the Health New Zealand and the Māori Health Authority:

Information to be supplied by health entities

(b) specifying information or classes of information that all health entities or a specified health entity must provide to the Director-General; and

(c) specifying the frequency of or time-frames for the provision of the information; and

(d) specifying the manner in which the information must be provided; and

(e) for the purpose of **section 92**,—

(i) specifying the form of any accountability document; and

(ii) specifying matters to be stated in any accountability document in addition to those required under this Act or the Crown Entities Act 2004:

New Zealand Health Plan

(f) in relation to the New Zealand Health Plan,—

(i) specifying the form of the plan; and

(ii) imposing requirements relating to the content of the plan; and

(iii) imposing procedural requirements (including engagement requirements for consultation) that must be complied with in the preparation of the plan:

Provision of services

(g) requiring Health New Zealand or the Māori Health Authority to provide or arrange for the provision of any specified services:

Entitlement cards

(h) providing for the issue of entitlement cards (including cards that may record information of any description that is capable of being read or processed by a computer, but not including cards that are themselves capable of processing information) to various classes of persons or the continuation of use of such cards issued under the Health Entitlement Cards Regulations 1993:

(i) prescribing the classes of persons eligible to be issued with the cards:

(j) prescribing and regulating the use of the cards, including (but not limited to)—

(i) their use to obtain any payment or exemption from payment for services supplied to the holder of a card, or their dependent spouse or partner or child:

(ii) specifying time limits on the validity of the cards:

(iii) requiring holders to return the cards to the Ministry of Health:

(iv) any other conditions relating to their use:

(k) providing for reviews or appeals, or both, of any decisions made under any regulations authorised by **paragraphs (h) to (j)**:

(l) prescribing offences relating to the improper use of the cards and the fines (not exceeding $10,000) that may be imposed in respect of any such offences:

Levies

(m) providing for returns to be made by persons importing into or manufacturing in New Zealand any alcohol, or any class or kind of alcohol, for the purpose of ascertaining the amount of any levy payable under this Act, and providing for the verification of returns:

(n) exempting any person or class of persons from paying any levy that would otherwise be payable under this Act in any case where the cost of assessing or collecting the levy exceeds the amount payable by way of the levy:

(o) amending or replacing the table in **Schedule 6**, and amending, omitting, or reinserting the description of the method for determining variable rates:

Dispute resolution

(p) for the purpose of **section 28**, prescribing procedural matters and requirements:

Eligible people

(q) specifying a class of eligible people who are eligible to receive publicly-funded services under this Act:

Procedural and other requirements

(2) The Minister must consult Health New Zealand and the Māori Health Authority before recommending the making of regulations under **subsection (1)(a)**.

(3) Regulations under **subsection (1)(o)** may be made only—

(a) for the purpose of aligning the rates for classes of alcohol under this Act with the classification system applied to alcoholic beverages under Part B of the Excise and Excise-equivalent Duties Table (as defined in section 5(1) of the Customs and Excise Act 2018); and

(b) after consultation with the Minister of Customs.

(4) The Minister must, before recommending the making of regulations under **subsection (1)(g)**,—

(a) have regard to—

(i) the objectives and functions of the health entity to whom the regulations apply; and

(ii) the New Zealand Health Plan, all health strategies, and any relevant locality plan; and

(b) consult the board of the health entity as to the services that are to be required to be provided or arranged, and the cost and funding of those services.

(5) Regulations under **subsection (1)(g)** may not—

(a) require the supply of services to or by any named individuals or organisations (other than Health New Zealand or the Māori Health Authority); or

(b) specify the price for any services.

(6) Regulations made under this section are secondary legislation (*see* Part 3 of the Legislation Act 2019 for publication requirements).

Subpart 4—Amendments to enactments

98 Enactments repealed and revoked

(1) The New Zealand Public Health and Disability Act 2000 is repealed.

(2) The enactments specified in Part 3 of Schedule 2 are revoked.

99 Consequential amendments

Amend the enactments specified in **Parts 1 and 2 Schedule 2** as set out in that schedule.

Schedule 1
Transitional, savings, and related provisions

s 8

Part 1
Provisions relating to this Act as enacted

1 Defined terms

In this Part, unless the context otherwise requires,—

assets has the meaning given in section 2(1) of the Health Sector (Transfers) Act 1993

collective agreement means a collective agreement (within the meaning of section 5 of the Employment Relations Act 2000) that is in force immediately before the commencement date

commencement date means the date specified in **section 2**

DHB means an organisation established by or under section 19 of the former Act

former Act means the New Zealand Public Health and Disability Act 2000

HPA or Health Promotion Agency means the agency established by section 57 of the former Act.

Subpart 1—Application of certain provisions of Act

2 New Zealand health strategy applies until health strategies take effect

(1) **Sections 37 to 43** (which require the making of the New Zealand Health Strategy, Hauora Māori Strategy, Pacific Health Strategy, and the Disability Health Strategy) do not take effect until 12 months after the commencement date.

(2) Until the date that **sections 37 to 43** take effect, the New Zealand health strategy determined under section 8(1) of the former Act continues in force and applies with all necessary modifications as if it were a health strategy under this Act.

3 Interim Health Plan applies until first New Zealand Health Plan takes effect

(1) The first New Zealand Health Plan made under **subpart 5 of Part 2** must take effect on a date no later than 2 years after the commencement date.

(2) The Interim Health Plan—

(a) applies on and from the commencement date until the date that the first New Zealand Health Plan takes effect; and

(b) until that date, must be treated as if it were the New Zealand Health Plan.

(3) In this clause, **Interim Health Plan** means a plan—

(a) developed by the following departmental agencies listed in Part 2 of Schedule 2 of the Public Service Act 2020:

(i) Health New Zealand; and

(ii) Maori Health Authority; and

(b) approved by the Minister for the purpose of this clause.

4 Determination of localities and locality plans

(1) **Section 48**, which requires localities to be determined, takes effect 2 years after the commencement date.

(2) **Section 49**, which requires a locality plan to be developed for each locality, takes effect 3 years after the commencement date.

5 Iwi-Māori partnership boards

An iwi-Māori partnership board that is listed in **Schedule 3** on the commencement date—

(a) is deemed to meet the criteria in **section 88(1)**; and

(b) comprises the members it had immediately before the commencement date; and

(c) to avoid doubt, may vary its membership in accordance with **section 88(2)**.

Subpart 2—New Zealand disability strategy continued

6 Continuation of New Zealand disability strategy

(1) Despite the repeal of the former Act,—

(a) the New Zealand disability strategy determined under section 8(2) of that Act continues in force; and

(b) the Minister of the Crown who is responsible for disability issues—

(i) must continue to determine a strategy, called the New Zealand disability strategy; and

(ii) may amend or replace that strategy at any time; and

(iii) must continue to comply with the requirements of section 8(3) to (5) of the former Act.

(2) This subpart expires and is repealed on a date determined by Order in Council made on the recommendation of the Minister of the Crown responsible for disability issues.

(3) An Order in Council made under this clause is secondary legislation (*see* Part 3 of the Legislation Act 2019 for publication requirements).

Subpart 3—Committees continued

7 Continuation of certain committees established under former Act

(1) A mortality review committee appointed under section 59 of the former Act continues as if it were a mortality review committee appointed under **section 75** of this Act.

(2) A committee established by the Minister under section 11 of the former Act continues as if it were established **section 82** of this Act.

(3) The national advisory committee on ethics governing health and disability support services appointed under section 13 of the former Act continues as if it were appointed under **section 86** of this Act.

(4) The public health advisory committee established under section 14 of the former Act continues as if it were established **section 82** of this Act.

(5) The pharmacology and therapeutics advisory committee established in accordance with section 50(1)(a) of the former Act continues as if it were established in accordance with **section 64(1)(a)** of this Act.

(6) The consumer advisory committee established in accordance with section 50(1)(b) of the former Act continues as if it were established in accordance with **section 64(1)(b)** of this Act

(7) A person who, immediately before the commencement date, was a member of a committee referred to in **subclauses (1) to (6)**, continues, subject to any terms and conditions of their appointment,—

(a) to be a member of the committee; and

(b) to hold any office on the committee that they held immediately before the commencement date.

Subpart 4—District Health Boards

8 District Health Boards disestablished

On the commencement date, all DHBs are disestablished.

9 Transfers

(1) On the commencement date,—

(a) all assets belonging to a DHB vest in Health New Zealand; and

(b) all information and documents held by a DHB are held by Health New Zealand; and

(c) all money payable to or by a DHB becomes payable to or by Health New Zealand; and

(d) all rights, liabilities, contracts, entitlements, undertakings, and engagements of a DHB become the rights, liabilities, contracts, entitlements, undertakings, and engagements of Health New Zealand; and

(e) subject to **subclause (5)**, every employee of a DHB becomes an employee of Health New Zealand on the same terms and conditions as applied immediately before they became an employee of Health New Zealand; and

(f) anything done, or omitted to be done, or that is to be done, by or in relation to a DHB is to be treated as having been done, or having been omitted to be done, or to be done, by or in relation to Health New Zealand; and

(g) proceedings, inquiries, and investigations under any enactment that may be commenced, continued, or enforced by or against a DHB (including as an interested party or intervenor) or in relation to a DHB may instead be commenced, continued, or enforced by or against or in relation to Health New Zealand without amendment to the proceedings; and

(h) a matter or thing that could, but for this clause, have been done or completed by a DHB may be done or completed by Health New Zealand.

(2) The transfer of information from a DHB to Health New Zealand under **subclause (1)** does not constitute an action that is an interference with the privacy of an individual under section 69 of the Privacy Act 2020.

(3) The disestablishment of a DHB does not, by itself, affect any of the following matters:

(a) any decision made, or anything done or omitted to be done, by a DHB in relation to the performance or exercise of its functions, powers, or duties under any enactment:

(b) any proceedings commenced by or against a DHB:

(c) any other matter or thing arising out of a DHB's performance or exercise, or purported performance or exercise, of its functions, powers, or duties under any enactment.

(4) Despite **subclause (1)(e)**, a chief executive of a DHB does not become an employee of Health New Zealand under this schedule.

10 Consequences of transfer for purposes of Inland Revenue Acts

For the purposes of the Inland Revenue Acts (as defined in section 3(1) of the Tax Administration Act 1994), a DHB and Health New Zealand are treated as the same person.

11 References to DHB, DHB's geographical area, or resident population

On and from the commencement date, unless the context otherwise requires, a reference in any enactment, notice, instrument, contract, or other document to—

(a) a District Health Board or DHB must be read as reference to Health New Zealand; and

(b) a DHB's geographical area or resident population must be read as a reference to the geographical area that the DHB previously represented, as set out in Schedule 1 of the former Act; and

(c) a DHB's resident population must be read as a reference to the resident population of the geographical area that the DHB previously represented, as set out in Schedule 1 of the former Act.

12 Terms and conditions of contracts and engagements of DHBs

To avoid doubt, if a contract or engagement of a DHB contains terms and conditions that are specific to that DHB, those terms and conditions apply only to parties within the DHB's region.

13 Collective agreements

(1) If a collective agreement to which more than 1 DHB is a party contains terms or conditions that apply to particular DHBs only, those terms or conditions—

(a) apply only to people who, immediately before the commencement date, were parties to the agreement or covered by those terms or conditions:

(b) must be offered by Health New Zealand to employees who, immediately before the commencement date, would have been offered those terms or conditions—

(i) unless the parties to the agreement agree otherwise; or

(ii) until the agreement expires or otherwise ceases to have effect.

(2) A collective agreement that covers the employees of some but not all DHBs continues after the commencement date to cover only those employees.

14 Application of section 62(4) of Employment Relations Act 2000

(1) **Subclause (2)** applies if—

(a) section 62 of the Employment Relations Act 2000 Act applies to an employee of Health New Zealand; and

(b) a collective agreement that applies to that employee's work is in force on the commencement date.

(2) If this subclause applies, the number of the employer's employees referred to section 62(4) of that Act is taken to mean the number of the employer's employees within the geographical region of the former DHB in which the employee's work will be performed.

(3) **Subclause (2)** applies—

(a) unless the parties to the collective agreement otherwise; or

(b) until the collective agreement expires or otherwise ceases to have effect.

15 Employment policies of DHB

(1) The employment policies of a DHB—

(a) continue to apply, after the commencement date, with all necessary modifications, as if they were employment policies of Health New Zealand; and

(b) may be replaced by Health New Zealand by written notice.

(2) Health New Zealand must undertake a reasonable consultation process before introducing any employment policy that is reasonably likely to have a material effect on employees.

Subpart 5—Health Promotion Agency

16 Health Promotion Agency disestablished

On the commencement date, the HPA is disestablished.

17 Transfers

(1) On the commencement date,—

(a) all assets belonging to the HPA vest in Health New Zealand; and

(b) all information and documents held by the HPA are held by Health New Zealand; and

(c) all money payable to or by the HPA becomes payable to or by Health New Zealand; and

(d) all rights, liabilities, contracts, entitlements, and engagements of the HPA become the rights, liabilities, contracts, entitlements, and engagements of Health New Zealand; and

(e) subject to **subclause (5)**, every employee of the HPA becomes an employee of Health New Zealand on the same terms and conditions as applied immediately before they became an employee of Health New Zealand; and

(f) anything done, or omitted to be done, or that is to be done, by or in relation to the HPA is to be treated as having been done, or having been omitted to be done, or to be done, by or in relation to Health New Zealand; and

(g) proceedings that may be commenced, continued, or enforced by or against the HPA (including as an interested party or intervenor) may instead be commenced, continued, or enforced by or against Health New Zealand without amendment to the proceedings; and

(h) a matter or thing that could, but for this clause, have been done or completed by the HPA may be done or completed by Health New Zealand.

(2) The transfer of information from the HPA to Health New Zealand under **subclause (1)** does not constitute an action that is an interference with the privacy of an individual under section 69 of the Privacy Act 2020.

(3) The disestablishment of the HPA does not, by itself, affect any of the following matters:

(a) any decision made, or anything done or omitted to be done, by the HPA in relation to the performance or exercise of its functions, powers, or duties under any enactment:

(b) any proceedings commenced by or against the HPA:

(c) any other matter or thing arising out of the HPA's performance or exercise, or purported performance or exercise, of its functions, powers, or duties under any enactment.

(4) Despite **subclause (1)(e)**, a chief executive of HPA does not become an employee of Health New Zealand under this schedule.

18 Consequences of transfer for purposes of Inland Revenue Acts

For the purposes of the Inland Revenue Acts (as defined in section 3(1) of the Tax Administration Act 1994), the HPA and Health New Zealand are treated as the same person.

Subpart 6—Transfer of employees

19 Defined term

In this subpart, unless the context otherwise requires, **redundancy payment** includes any payment or other benefit provided on the ground of a person's position being disestablished or changed.

20 No redundancy payment for transferred employee

(1) This section applies if rights and obligations of—

(a) a DHB under a contract of service between the DHB and an employee of the DHB are transferred to Health New Zealand under **subpart 4**; or

(b) the HPA under a contract of service between the HPA and an employee of the HPA are transferred to Health New Zealand under **subpart 5**.

(2) An employee who is to be transferred under **subpart 4 or 5** is not entitled to a redundancy payment.

(3) If any rights and obligations of a DHB or the HPA under a contract of service arise by virtue of a collective employment contract and such rights and obligations are transferred to Health New Zealand under **subpart 4 or 5**, that collective employment contract is be deemed, on and from the commencement date to continue to apply on the same terms (including any terms relating to new employees) as if it were a contract made between Health New Zealand, any bargaining agent that is a party to it, and the employee.

21 Other restrictions on redundancy payments

(1) An employee of a DHB or the HPA who has received a notice of termination by reason of redundancy is not entitled to a redundancy payment if, before the employee's employment has ended, the employee—

(a) is offered and accepts another position as an employee of the Ministry or Health New Zealand that—

(i) begins before, on, or immediately after the date on which the employee's current position ends; and

(ii) is on terms and conditions of employment (including redundancy and superannuation conditions) that are no less favourable; and

(iii) is on terms that treat service within the Ministry or Health New Zealand as if it were continuous service; or

(b) is offered an alternative position as an employee in the Ministry that—

(i) begins before, on, or immediately after the date on which the employee's current position ends; and

(ii) is a position with comparable duties and responsibilities to those of the employee's current position; and

(iii) is in substantially the same general locality or a locality within reasonable commuting distance; and

(iv) is on terms and conditions of employment (including redundancy and superannuation conditions) that are no less favourable; and

(v) is on terms that treat service within the Ministry as if it were continuous service.

(2) This section overrides Part 6A of the Employment Relations Act 2000.

22 Employment continuous for purpose of certain enactments

(1) If an employee of a DHB or the HPA is moving by virtue of **subpart 4 or 5** to be an employee of Health New Zealand, their employment is to be treated as continuous for the purposes of—

(a) entitlements under the following provisions in Part 2 of the Holidays Act 2003:

(i) subpart 1 (annual holidays); and

(ii) subpart 3 (public holidays); and

(iii) subpart 4 (sick leave and bereavement leave); and

(iv) subpart 5 (family violence leave); and

(b) entitlements to leave under the Parental Leave and Employment Protection Act 1987; and

(c) the KiwiSaver Act 2006.

(2) For the purpose of **subclause (1)(a)**,—

(a) the period of employment of the employee in the DHB or the HPA that ends with the date on which the employee moved to Health New Zealand must be treated as a period of employment with Health New Zealand for the purpose of determining the employee's entitlement to annual holidays, sick leave, bereavement leave, and family violence leave; and

(b) the chief executive of the DHB or the HPA must not pay the employee for annual holidays, or alternative holidays, not taken before the date on which the employee moved to the position in Health New Zealand; and

(c) the chief executive of Health New Zealand must recognise the employee's entitlement to—

(i) any sick leave, including any sick leave carried over under section 66 of the Holidays Act 2003, not taken before the date on which the employee moved to the position in Health New Zealand; and

(ii) any annual holidays not taken before the date on which the employee moved to the position in Health New Zealand; and

(iii) any alternative holidays not taken or exchanged for payment under section 61 of that Act before the date on which the employee moved to the position in Health New Zealand; and

(iv) any holidays not taken before the date on which the employee moved to the position in Health New Zealand in relation to which there was an agreement between the employee and the DHB or the HPA (as the case may be) under section 44A or 44B of that Act.

(3) For the purpose of **subclause (1)(b)**,—

(a) the period of employment of the employee in the DHB or the HPA that ends with the date on which the employee moved to Health New Zealand must be treated as a period of employment with Health New Zealand; and

(b) the chief executive of Health New Zealand must treat any notice given to or by the chief executive of the DHB or the HPA under the Parental Leave and Employment Protection Act 1987 as if it had been given to or by the chief executive of Health New Zealand.

(4) If the employee's position with Health New Zealand (position A) begins before the date on which the employee's position with DHB or the HPA (position B) ends, **subclauses (2) and (3)** must be applied as if position B ends on the date that position A begins.

(5) For the purpose of **subclause (1)(c)**, the employment of the employee in the position with Health New Zealand is not new employment within the meaning of that term in the KiwiSaver Act 2006.

23 Application of sections 14 and 15 of Health Sector Transfers Act 1993

(1) Section 14 of the Health Sector Transfers Act 1993—

(a) applies with all necessary modifications to a person who becomes an employee of Health New Zealand by operation of **clause 9 or 17**; and

(b) must read as if the contract of service were transferred under **clause 9 or 17** of this Schedule.

(2) Section 15 of the Health Sector Transfers Act 1993 applies to an employee who becomes an employee of Health New Zealand by operation of **clause 9 or 17**.

Subpart 7—Existing directions and notices under former Act

24 Ministerial directions

(1) Despite the repeal of the former Act, a ministerial direction given under section 32 of that Act or section 103 of the Crown Entities Act 2004 in relation to an entity established under the former Act—

(a) continues in force on and after the commencement date; and

(b) ceases to have effect on a date specified by the Minister by Order in Council.

(2) An Order in Council made under this clause is secondary legislation (*see* Part 3 of the Legislation Act 2019 for publication requirements).

25 Notices relating to payment arrangements

Despite the repeal of the former Act, a notice given under section 88 of that Act—

(a) continues in force on and after the commencement date; and

(b) is deemed to have been made under **section 90** of this Act.

Schedule 2
Consequential amendments to enactments

s 99

Part 1
Amendment to Acts

Abortion Legislation Act 2020 (2020 No 6)

In section 16(1), replace "the New Zealand Public Health and Disability Act 2000" with "the Pae Ora (Healthy Futures) Act **2021**".

Accident Compensation Act 2001 (2001 No 49)

In section 6(1), repeal the definition of **district health board or other provider** and insert in its appropriate alphabetical order:

> **Health New Zealand, Māori Health Authority or other provider** means Health New Zealand, Māori Health Authority or other provider, as defined in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In section 6(1), replace the definition of **Crown funding agreement** with:

> **Crown funding agreement** has the same meaning as in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In section 6(1), insert in its appropriate alphabetical order:

> **Māori Health Authority** means the Māori Health Authority established by **section 21 of the Pae Ora (Healthy Futures) Act 2021**

In section 74(4), replace "a district health board or the Minister or Health" with "Health New Zealand, the Māori Health Authority or the Minister of Health".

In section 282(1), replace "district health boards" with "Health New Zealand and the Māori Health Authority".

In section 282(4), replace "a district health board" with "Health New Zealand or the Maori Health Authority".

In section 282(8), replace "a district health board authorised by the" with "Health New Zealand or the Maori Health Authority authorised by it's".

In section 301(2)(a)(i), replace "district health boards" with "Health New Zealand, the Maori Health Authority".

In section 302(1), replace "district health boards" with "Health New Zealand, the Maori Health Authority".

In section 303(1), replace "district health board" with "Health New Zealand, the Maori Health Authority".

In section 305(1), replace "district health board" with "Health New Zealand".

Artificial Limb Service Act 2018 (2018 No 34)

In section 10(d), replace "District Health Boards" with "Health New Zealand".

Biosecurity Act 1993 (1993 No 95)

In section 87(1)(g), replace "DHBs, as defined in section 6 of the New Zealand Public Health and Disability Act 2000" with "Health New Zealand, as defined in **section 4 of the Pae Ora (Healthy Futures) Act 2021**".

In section 98(1)(g), replace "DHBs, as defined in section 6 of the New Zealand Public Health and Disability Act 2000" with "Health New Zealand, as defined in **section 4 of the Pae Ora (Healthy Futures) Act 2021**".

Births, Deaths, Marriages, and Relationships Registration Act 1995 (1995 No 16)

In section 85A(1), replace "the New Zealand Public Health and Disability Act 2000" with "the Pae Ora (Healthy Futures) Act **2021**".

Charitable Trusts Act 1957 (1957 No 18)

In section 51(2)(b), replace "any district health board" with "Health New Zealand".

Children's Act 2014 (2014 No 40)

In section 5(1), definition of **children's agencies**, replace paragraph (c) with:

(c) Pae Ora (Healthy Futures) Act **2021**:

In section 14(a), replace "DHBs boards" with "the boards of Health New Zealand and the Māori Health Authority".

In section 15(1), replace the definition of **board** with:

> **board**, in relation to Health New Zealand or the Māori Health Authority, means the members of the board of that organisation (who number no less than the required quorum) acting together as a board

In section 15(1), repeal the definition of **DHB** and insert in its appropriate alphabetical order:

> **Health New Zealand** has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In section 15(1), definition of **independent person**, replace "a DHB" with "Health New Zealand or the Māori Health Authority".

In section 15(1), insert in its appropriate alphabetical order:

> **Māori Health Authority** means the Māori Health Authority established by **section 17 of the Pae Ora (Healthy Futures) Act 2021**

In section 15(4)(a), replace "DHBs" with "Health New Zealand".

In the heading to section 17, replace "**DHBs boards**" with "**Health New Zealand and Maori Health Authority**".

Children's Act 2014 (2014 No 40)—*continued*

In section 17, replace "Every board of a DHB must" with "The board of Health New Zealand and the board of the Maori Health Authority must each".

In section 17(a), delete "after the commencement (under section 2(1)) of this section".

Civil Defence Emergency Management Act 2002 (2002 No 33)

In section 4, replace the definition of **health and disability services** with:

> **health and disability services** means services as defined in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In section 4, replace the definition of **provider of health and disability services** with:

> **provider of health and disability services** means a provider as defined in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

Compensation for Live Organ Donors Act 2016 (2016 No 96)

In section 9(1)(c), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

Contraception, Sterilisation, and Abortion Act 1977 (1977 No 112)

In section 16(1), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

Crown Entities Act 2004 (2004 No 115)

Repeal section 98(1A).

In Schedule 1, Part 1, table, repeal the items relating to District Health Boards and Health Promotion Agency.

In Schedule 1, Part 1, table, insert the item its appropriate alphabetical order:

Health New Zealand

Customs and Excise Act 2018 (2018 No 4)

In Schedule 1, Part 1, clause 1(7)(c), replace "Schedule 4A of the New Zealand Public Health and Disability Act 2000" with "**Schedule 5 of the Pae Ora (Healthy Futures) Act 2021**".

Disabled Persons Community Welfare Act 1975 (1975 No 122)

In section 2, repeal the definitions of **Crown funding agreement**, **disability services**, **district health board**, and **service agreement**.

In section 2, insert in their appropriate alphabetical order:

> **Crown funding agreement** has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

Disabled Persons Community Welfare Act 1975 (1975 No 122)—*continued*

disability support services has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

Health New Zealand has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

Māori Health Authority has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

service agreement means an agreement in which 1 or more health entities as defined in **section 4 of the Pae Ora (Healthy Futures) Act 2021** agree to provide money to a person in return for the person providing services within the meaning of section 4 of that Act or arranging for the provision of those services

In section 4(e), replace "district health boards" with "Health New Zealand, the Māori Health Authority,".

In section 25A(1)(b), replace "section 88 of the New Zealand Public Health and Disability Act 2000" with "**section 87 of the Pae Ora (Healthy Futures) Act 2021**".

In section 25A(2)(a) and (b), replace "section 88 of the New Zealand Public Health and Disability Act 2000" with "**section 87 of the Pae Ora (Healthy Futures) Act 2021**".

In section 25C(3)(d), replace "district health board" with "Health New Zealand or the Māori Health Authority".

In section 25C(3)(d)(i), replace "section 88 of the New Zealand Public Health and Disability Act 2000" with "**section 87 of the Pae Ora (Healthy Futures) Act 2021**".

In section 25D(4)(c), replace "section 88 of the New Zealand Public Health and Disability Act 2000" with "**section 87 of the Pae Ora (Healthy Futures) Act 2021**".

Education and Training Act 2020 (2020 No 38)

In section 10, definition of **early childhood education and care centre**, replace paragraph (c)(iv) with:

(iv) institutions under the control of the Ministry of Health, Health New Zealand, or the Māori Health Authority:

Employment Relations Act 2000 (2000 No 24)

In section 100E(2)(a)(i), replace "not less than three quarters of district health boards" with "Health New Zealand".

In section 100E(2)(a)(ii), replace "district health boards" with "Health New Zealand".

In Schedule 1, Part A, clause 13, replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

Employment Relations Act 2000 (2000 No 24)—*continued*

In the heading to Schedule 1B, replace "**sector**" with "**system**".

In Schedule 1B, replace clause 1(1) to (3) with:

(1) This code applies to the following parties to an employment relationship in the public health system:

- (a) Health New Zealand and the Māori Health Authority:
- (b) employees of Health New Zealand or the Māori Health Authority:
- (c) unions whose members are employees of Health New Zealand or the Māori Health Authority:
- (d) other employers to the extent that they provide services to Health New Zealand, the Māori Health Authority, or the New Zealand Blood and Organ Service:
- (e) employees of the employers referred to in **paragraph (d)** to the extent that they are engaged in providing services to Health New Zealand, the Māori Health Authority, or the New Zealand Blood and Organ Service:
- (f) the New Zealand Blood and Organ Service:
- (g) employees of the New Zealand Blood and Organ Service:
- (h) unions whose members are employees of the New Zealand Blood and Organ Service.

(2) However, to avoid doubt, **subclause (1)(d) and (e)** applies in relation to the provision of services only if the services are provided to Health New Zealand, the Māori Health Authority, or the New Zealand Blood and Organ Service in its role as a provider of services.

(3) Before Health New Zealand, the Māori Health Authority, or the New Zealand Blood and Organ Service enters into an agreement or arrangement with another employer for the provision of services to it, it must notify the employer that this code will apply to the employer in relation to the provision of those services.

In Schedule 1B, clause 2, replace "sector" with "system" in each place.

In Schedule 1B, clause 3, definition of **services**, replace paragraph (a) with:

- (a) has the same meaning as in **section 4 of the Pae Ora (Healthy Futures) Act 2021**; and

In Schedule 1B, clause 3, definition of **good employer**, replace "section 6(1) of the New Zealand Public Health and Disability Act 2000" with "has the same meaning as in section 118 of the Crown Entities Act 2004".

In Schedule 1B, clause 4(2)(d)(i), replace "sector" with "system".

In Schedule 1B, replace clause 7 with:

Employment Relations Act 2000 (2000 No 24)—*continued*

7 Health system principles

The parties must recognise and support the health system principles in **section 7(1) of the Pae Ora (Healthy Futures) Act 2021**.

In Schedule 1B, clause 18, replace "sector" with "system".

In Schedule 1B, replace clause 19(1)(a) with:

(a) an employer is Health New Zealand, the Māori Health Authority, or the New Zealand Blood and Organ Service; and

In Schedule 1B, clause 20(1), replace "a district health board or the New Zealand Blood Service" with "Health New Zealand, the Māori Health Authority, the New Zealand Blood and Organ Service" in each place.

In Schedule 1B, clause 21(1), replace "a district health board or the New Zealand Blood Service" with "Health New Zealand, the Māori Health Authority, the New Zealand Blood and Organ Service".

Family Violence Act 2018 (2018 No 46)

In section 19, definition of **specified government agency**, replace paragraph (e) with:

(e) Health New Zealand (that is, Health New Zealand established by **section 11 of the Pae Ora (Healthy Futures) Act 2021**):

In section 19, definition of **specified government agency**, after paragraph (m), insert:

(n) Māori Health Authority (that is, the Māori Health Authority established by **section 17 of the Pae Ora (Healthy Futures) Act 2021**)

Finance Act 1994 (1994 No 73)

In section 2(2), replace "(reached before the commencement of the New Zealand Public Health and Disability Act 2000)" with "(reached before 1 January 2001)".

Goods and Services Act 1985 (1985 No 141)

Replace section 25(7) with:

(7) In this section,—

Pharmac means the Pharmaceutical Management Agency continued by **section 58 of the Pae Ora (Healthy Futures) Act 2021**

Pharmac agreement means an agreement to which Pharmac is a party and under which Pharmac agrees to list a pharmaceutical on the pharmaceutical schedule as defined in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

pharmaceutical means a pharmaceutical as defined in **section 4 of the Pae Ora (Healthy Futures) Act 2021**.

Hazardous Substances and New Organisms Act 1996 (1996 No 30)

In section 2(1), definition of **public health**, replace "section 6(1) of the New Zealand Public Health and Disability Act 2000" with "**section 4 of the Pae Ora (Healthy Futures) Act 2021**".

Health Act 1956 (1956 No 65)

In section 2(1), repeal the definitions of **district health board**, **personal health**, **personal health services**, **public health**, and **public health services**.

In section 2(1), insert in their appropriate alphabetical order:

Health New Zealand has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

Māori Health Authority has the meaning in **section 4 the Pae Ora (Healthy Futures) Act 2021**

personal health has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

personal health services has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

public health has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

public health services has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

Repeal section 3B(3)(b).

Section 3E, heading, replace "Group" with "Agency".

In section 3E(1) and (2), replace "Group" with "Agency".

Replace section 3E(3) with:

(3) The functions of the Public Health Agency are—

(a) to provide systems leadership across the public health sector; and

(b) to advise the Director-General on matters relating to public health, including—

(i) personal health matters relating to public health; and

(ii) regulatory and strategic matters relating to public health.

3E Public Health Agency

In the heading to section 3F, replace "**Group**" with "**Agency**".

In section 3F, replace "Group's" with "Agency's".

In section 3F, replace "Group" with "Agency".

After section 7A(8), insert:

Health Act 1956 (1956 No 65)—*continued*

(9) To avoid doubt, the Director-General may revoke a designation of a person as a medical officer of health or health or protection officer under this section.

(10) The Director-General must consult the Director of Public Health before revoking a designation of a medical officer of health.

After section 22(2), insert:

(3) A person who holds office as Director of Public Health has the functions of a medical officer of health and may exercise them in any part of New Zealand if they are a medical practitioner specialising in public health.

In section 22B, definition of **services**, replace "section 6(1) of the New Zealand Public Health and Disability Act 2000" with "**section 4 of the Pae Ora (Healthy Futures) Act 2021**".

Replace section 22C(2)(j) with:

(j) an employee of Health New Zealand, for the purposes of exercising or performing any of Health New Zealand's powers, duties, or functions of under the Pae Ora (Healthy Futures) Act **2021**:

(k) an employee of the Māori Health Authority, for the purposes of exercising or performing any of the Māori Health Authority's powers, duties, or functions under the Pae Ora (Healthy Futures) Act **2021**.

In section 22D(1), replace "any district health board" with "Health New Zealand or the Māori Health Authority".

In section 22D(2), replace "a district health board" with "Health New Zealand or the Māori Health Authority".

In section 22E, replace "a district health board" with "Health New Zealand or the Māori Health Authority".

In section 22G(1), afer paragraph (i), insert:, replace "a district health board" with "Health New Zealand".

After section 22G(1)(i), insert:

(j) Health New Zealand:

(k) Māori Health Authority.

In section 22G(2), replace "a district health board" with "Health New Zealand or the Māori Health Authority".

In section 22G(2)(a), replace "the district health board" with "Health New Zealand or the Māori Health Authority".

In section 92ZA(3), replace "a district health board, the district health board" with "Health New Zealand, Health New Zealand".

In section 92ZZA(1)(c), replace "the district health board" with "Health New Zealand".

In section 112J(2)(d), replace "district health board" with "Health New Zealand".

Health Act 1956 (1956 No 65)—*continued*

In section 112J(2)(e) and (3), replace "a district health board" with "Health New Zealand".

Health and Disability Commissioner Act 1994 (1994 No 88)

Replace section 7(a) and (b) with:

(a) take into account the Government Policy Statement on Health, and any health strategy issued under the Pae Ora (Healthy Futures) Act **2021**, so far as those strategies are applicable to the circumstances of the particular case; and

(b) take into account the objectives for Health New Zealand set out in **section 13 of the Pae Ora (Healthy Futures) Act 2021** and the objectives of the Māori Health Authority set out in **section 18 of the Pae Ora (Healthy Futures) Act 2021**.

Health and Disability Services (Safety) Act 2001 (2001 No 93)

In section 5(1)(c), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In section 31(4)(a), replace "a District Health Board" with "Health New Zealand".

Health Practitioners Competence Assurance Act 2003 (2003 No 48)

In section 53, definition of **investigation**, replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In section 60(6), replace "clause 2 of Schedule 5 of the New Zealand Public Health and Disability Act 2000" with "**clause 2 of Schedule 4 of the Pae Ora (Healthy Futures) Act 2021**".

In section 61(1)(b), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

Health Sector (Transfers) Act 1993 (1993 No 23)

In section 2(1), definition of **Crown endowment**,—

(a) replace "a DHB" with "Health New Zealand"; and

(b) replace "the DHB" with "Health New Zealand".

In section 2(1), replace definition of **Crown endowment land** with:

Crown endowment land means, in relation to Health New Zealand, land that—

(a) is vested in Health New Zealand as a Crown endowment; and

(b) was either—

(i) granted by the Crown to Health New Zealand or to any of its predecessors in title; or

Health Sector (Transfers) Act 1993 (1993 No 23)—*continued*

(ii) vested in Health New Zealand or in any of its predecessors in title by or pursuant to any Act, Provincial Ordinance, grant, or Order in Council; and

(c) was not land that, before it was granted to, or vested in, Health New Zealand or any of its predecessors in title, had been given to the Crown, whether in trust or otherwise; and

(d) is not a public reserve within the meaning of the Reserves Act 1977; and

(e) is not, except for being held as a Crown endowment, land that is held in trust for a particular purpose; and

(f) is not, except for being held as a Crown endowment, land in respect of which special provision is made by any Act or Provincial Ordinance

In section 2(1), repeal the definition of **HPA**.

In section 2(1), inserted in its appropriate alphabetical order:

Māori Health Authority has the meaning in **section 4 the Pae Ora (Healthy Futures) Act 2021**

In section 2(1), definition of **predecessor in title**, replace "a DHB, means any of its predecessors in title that was" with "Health New Zealand, means any of its predecessors in title that was a DHB,".

In section 2(1), replace definition of **publicly-owned health and disability organisation** with:

publicly-owned health and disability organisation means—

(a) Health New Zealand, Māori Health Authority, NZBOS, HQSC, and Pharmac; and

(b) includes any companies wholly or partially owned by those organisations

In section 2(2), replace "section 6(1) of the New Zealand Public Health and Disability Act 2000" with "**section 4 of the Pae Ora (Healthy Futures) Act 2021**".

In section 2A(b)(ii) and (c), replace "DHBs" with "Health New Zealand or the Māori Health Authority".

In the heading to section 11A, replace "**DHB**" with "**Health New Zealand and Māori Health Authority**".

Replace section 11A(1) with:

(1) Subject to this section and **section 95 of the Pae Ora (Healthy Futures) Act 2021**, the powers of Health New Zealand or the Māori Health Authority to sell, exchange, mortgage, or charge land may be exercised by Health New Zealand or the Māori Health Authority in respect of land held in trust for any purpose, despite the terms of that trust.

Health Sector (Transfers) Act 1993 (1993 No 23)—*continued*

In section 11A(6), replace "a DHB" with "Health New Zealand or the Māori Health Authority".

In section 11B(1), replace "a DHB, declare that any land vested in the DHB" with "Health New Zealand or the Māori Health Authority, declare that any land vested in Health New Zealand or the Māori Health Authority.".

Replace section 11B(2) with:

(b) subject to **section 95 of the Pae Ora (Healthy Futures) Act 2021**, may be sold, exchanged, mortgaged, charged, or otherwise dealt with by Health New Zealand or the Māori Health Authority free from the terms of the Crown endowment.

In section 11B(3), replace "a DHB" with "Health New Zealand or the Māori Health Authority".

Replace section 11C(1) with:

(1) Subject to subsection (2), where Health New Zealand or the Māori Health Authority holds in trust the proceeds of the sale of any land (being land that was, at the time of the sale, subject to a Crown endowment), Health New Zealand or the Māori Health Authority may, despite the terms of that endowment, and whether the land was sold before or after the commencement of this section, apply the proceeds of the sale—

(a) for the purposes of any health services or disability support services, or both, provided by Health New Zealand or the Māori Health Authority; or

(b) for any purpose for which Health New Zealand or the Māori Health Authority may lawfully apply its own property.

In section 11C(2), replace "the DHB" with "Health New Zealand or the Māori Health Authority".

In section 11C(3), replace "a DHB" with "Health New Zealand or the Māori Health Authority".

In section 11D, replace "a DHB" with "Health New Zealand or the Māori Health Authority".

In section 11E(8)(a), replace "clause 43 of Schedule 3 or clause 28 of Schedule 6 of the New Zealand Public Health and Disability Act 2000" with "**section 95 of the Pae Ora (Healthy Futures) Act 2021**".

In section 11E(8)(b), replace "clause 43 of Schedule 3 of the New Zealand Public Health and Disability Act 2000" with "**section 95 of the Pae Ora (Healthy Futures) Act 2021**".

Replace section 11H(2)(a)(i) with:

(i) before being transferred to, or vested in, the transferee under this Act or the Pae Ora (Healthy Futures) Act **2021** had been given to

Health Sector (Transfers) Act 1993 (1993 No 23)—*continued*

the Crown, Health New Zealand, the Māori Health Authority, or any predecessors in title of Health New Zealand; and

Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016 (2016 No 2)

In the Preamble, subsection (2), replace "District Health Boards" with "the predecessors of Health New Zealand".

In section 4, repeal the definition of **DHB** and insert in its appropriate alphabetical order:

Health New Zealand has the meaning in **section 4 the Pae Ora (Healthy Futures) Act 2021**

In section 4, definition of **home and community-based support services**, paragraph (a)(i), replace "services funded by the Ministry of Health or a DHB" with "services funded by the Ministry of Health, Health New Zealand, or the Māori Health Authority".

In section 4, definition of **home and community-based support services**, paragraph (b)(ii), replace "Ministry of Health to allow" with "Ministry of Health or another agency to allow".

In section 4, insert in its appropriate alphabetical order:

Māori Health Authority has the meaning in **section 4 the Pae Ora (Healthy Futures) Act 2021**

In section 8(1)(b), replace "a former HCS employer, ACC, or the Crown" with "a former HCS employer, Health New Zealand, ACC, or the Crown".

In section 8(3)(a) and (b), replace "a former HCS employer, ACC, or the Crown" with "a former HCS employer, Health New Zealand, ACC, or the Crown".

Replace the heading to section 15 with "**Minimum amounts payable for travel before 1 March 2016 funded by Ministry of Health or Health New Zealand**".

Replace section 28(2)(b) with:

(b) Health New Zealand:

Replace section 29(2)(c) with:

(c) Health New Zealand; and

In Schedule 3, repeal the items relating to Auckland DHB, Canterbury DHB, Hawke's Bay DHB, Nelson Marlborough DHB, Tairawhiti DHB (also known as Tairawhiti District Health and TDH), Waikato DHB, and West Coast DHB.

In Schedule 3, insert the following item in its appropriate alphabetical order:

Health New Zealand

Human Assisted Reproductive Technology Act 2004 (2004 No 92)

Replace section 27(3)(a) with:

> (a) complies in its composition with any applicable standard governing ethics committees determined by any relevant committee appointed under **section 82 of the Pae Ora (Healthy Futures) Act 2021**; and

Replace section 27(4) with:

> (4) The committee designated under this section is subject to any applicable ethical standards determined by any relevant committee appointed under **section 82 of the Pae Ora (Healthy Futures) Act 2021**.

Immigration Act 2009 (2009 No 51)

In heading to section 300, replace "**publicly funded health and disability support services**" with "**services**".

In section 300(1)(a) and (b), replace "publicly funded health and disability support services" with "services".

In section 300(3)(a), (b), and (c), replace "publicly funded health and disability support services" with "services".

In section 300(9), repeal the definition of **publicly funded health and disability support services**.

In section 300(9), definition of **responsible department**, replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In section 300(9), insert its appropriate alphabetical order:

> **services** has the meaning in section 4 of the Pae Ora (Healthy Futures) Act **2021**

Income Tax Act 2007 (2207 No 97)

In section CW 53B(1), replace "the Ministry of Health or a District Health Board" with "Health New Zealand or the Māori Health Authority".

In section CW 52B(2), definition of **disability support services**, replace "section 6(1) of the New Zealand Public Health and Disability Act 2000" with "**section 4 of the Pae Ora (Healthy Futures) Act 2021**".

In section LY 3(2)(d)(ii), replace "a district health board" with "Health New Zealand".

In section MX 2(c)(ii), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

Inquiries Act 2013 (2013 No 60)

In Schedule 1, repeal the item relating to New Zealand Public Health and Disability Act 2000.

Land Transport Act 1998 (1998 No 110)

In section 73(7), replace "a district health board" with "Health New Zealand".

Local Electoral Act 2001 (2001 No 35)

Repeal section 7(f).

Local Government (Rating) Act 2002 (2002 No 6)

In Schedule 1, Part 1, clause 8, replace "a district health board" with "Health New Zealand".

Local Government Act 1974 (1974 No 66)

In section 2(1), repeal the definition of **district health board**.

Maritime Transport Act 1994 (1994 No 104)

In section 40M(7), replace "a district health board," with "Health New Zealand,".

Medicines Act 1981 (1981 No 118)

Replace section 49A(3)(b) with:

(b) officers and employees of Health New Zealand established by **section 11 of the Pae Ora (Healthy Futures) Act 2021**:

Mental Health (Compulsory Assessment and Treatment) Act 1992 (1992 No 46)

In section 2(1), definition of **service**, replace paragraph (a) with:

(a) funded by or through a Crown funding agreement within the meaning of **section 4 of the Pae Ora (Healthy Futures) Act 2021**; or

Misuse of Drugs Act 1975 (1975 No 116)

In section 8(1)(b)(i), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In section 8(1)(f), replace "any district health board established by the New Zealand Public Health and Disability Act 2000" with "Health New Zealand established by **section 11 of the Pae Ora (Healthy Futures) Act 2021**".

Replace section 20(3)(a) with:

(a) employees of Health New Zealand established by **section 11 of the Pae Ora (Healthy Futures) Act 2021**:

New Zealand Sign Language Act 2006 (2006 No 18)

Replace section 10(2) with:

(2) A report under subsection (1) may be included in any report referred to in **clause 6 of Schedule 1 of the Pae Ora (Healthy Futures) Act 2021** on the progress being made in implementing the New Zealand disability strategy.

New Zealand Superannuation and Retirement Income Act 2001 (previously named the New Zealand Superannuation Act 2001) (2001 No 84)

In section 19(1), replace "a District Health Board within the meaning of the New Zealand Public Health and Disability Act 2000" with "Health New Zealand established by **section 11 of the Pae Ora (Healthy Futures) Act 2021**".

Ngā Mana Whenua o Tāmaki Makaurau Collective Redress Act 2014 (2014 No 52)

In the heading to section 137, replace "**district health boards**" with "**Health New Zealand**".

In section 137(1),—

(a) replace "A district health board may dispose" with "Health New Zealand may dispose"; and

(b) replace "the district health board's objectives" with "Health New Zealand's objectives".

Repeal section 137(2).

Ngāi Tahu Claims Settlement Act 1998 (1998 No 97)

In section 50(j), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

Ngāti Hauā Claims Settlement Act 2014 (2014 No 75)

In section 109(1)(a)(ii), replace "Waikato District Health Board" with "Health New Zealand".

Replace section 126 with:

126 Disposal by Health New Zealand

Health New Zealand (established by **section 11 of the Pae Ora (Healthy Futures) Act 2021**), or any of its subsidiaries, may dispose of RFR land to any person if the Minister of Health has given notice to the trustees that, in the Minister's opinion, the disposal will achieve, or assist in achieving, Health New Zealand's objectives.

Ngāti Toa Rangatira Claims Settlement Act 2014 (2014 No 17)

Replace section 202 with:

202 Disposals by Health New Zealand

Health New Zealand (established by **section 11 of the Pae Ora (Healthy Futures) Act 2021**), or any of its subsidiaries, may dispose of RFR land to any person if the Minister of Health has given notice to the trustees that, in the Minister's opinion, the disposal will achieve, or assist in achieving, Health New Zealand's objectives.

Ombudsmen Act 1975 (1975 No 9)

In section 2(2)(b), replace "a district health board if the district health board, whether alone or together with any other district health board," with "Health New Zealand if Health New Zealand,".

After section 2(2)(c), insert:

(d) the Māori Health Authority if the Māori Health Authority directly or indirectly owns, or controls the exercise of all the voting rights attaching to, the issued shares of the company (other than shares that carry no right to participate beyond a specified amount in a distribution of either profits or capital).

In Schedule 1, Part 1A, repeal the items relating to Cancer Control Agency, Health New Zealand, and Māori Health Authority.

In Schedule 1, Part 2, repeal the following items:

District health boards

District Health Boards New Zealand Incorporated

Health Promotion Agency

New Zealand Blood Service

Related companies of district health boards (within the meaning of section 2(2)(b))

In Schedule 1, Part 2, insert in their appropriate alphabetical order:

Health New Zealand

Māori Health Authority

New Zealand Blood and Organ Service

Related companies of Health New Zealand

Related companies of the Māori Health Authority

Oranga Tamariki Act 1989/Children's and Young People's Well-being Act 1989 (previously named the Children, Young Persons, and Their Families Act 1989) (1989 No 24)

In section 2(1), definition of **child welfare and protection agency**, replace paragraph (j) with:

(j) Health New Zealand:

In section 2(1), definition of **child welfare and protection agency**, after paragraph (n), insert:

(o) the Māori Health Authority

In section 2(1), repeal the definition of **DHB** and insert in its appropriate alphabetical order:

Health New Zealand has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In section 2(1), insert in its appropriate alphabetical order:

Oranga Tamariki Act 1989/Children's and Young People's Well-being Act 1989 (previously named the Children, Young Persons, and Their Families Act 1989) (1989 No 24)—*continued*

Māori Health Authority has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

Parental Leave and Employment Protection Act 1987 (1987 No 129)

Repeal section 2AB.

Port Nicholson Block (Taranaki Whānui ki Te Upoko o Te Ika) Claims Settlement Act 2009 (2009 No 26)

Replace section 109 with:

109 Disposals by Health New Zealand

Health New Zealand (as defined in **section 4 of the Pae Ora (Healthy Futures) Act 2021**), or any of its subsidiaries, may dispose of RFR land to any person if the Minister of Health has given notice to the trustees that, in the Minister's opinion, the disposal will achieve, or assist in achieving, Health New Zealand's objectives.

Privacy Act 2002 (2002 No 31)

In section 138, definition of **specified organisation**, replace paragraph (c) with:

(c) Health New Zealand:

In section 138, definition of **specified organisation**, after paragraph (j), insert:

(k) Māori Health Authority

In Schedule 3, table, replace each reference to "District Health Boards" with "Health New Zealand and Māori Health Authority".

Prohibition of Gang Insignia in Government Premises Act 2013 (2013 No 56)

In section 4, repeal the definition of **district health board** and insert in its appropriate alphabetical order:

Health New Zealand has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In section 4, definition of **Government premises**, replace paragraph (c)(i) with:

(i) Health New Zealand; and

Public Service Act 2020 (2020 No 40)

In Schedule 2, Part 2, repeal the items relating to Cancer Control Agency, Health New Zealand, and Māori Health Authority.

Psychoactive Substances Act 2013 (2013 No 53)

In section 8, definition of **public health**, replace "section 8(1) of the New Zealand Public Health and Disability Act 2000" with "**section 4 of the Pae Ora (Healthy Futures) Act 2021**".

Raukawa Claims Settlement Act 2014 (2014 No 7)

In section 106(1)(a)(ii), replace "the Waikato District Health Board" with "Health New Zealand".

Replace section 124 with:

124 Disposal by Health New Zealand

Health New Zealand (established by **section 11 of the Pae Ora (Healthy Futures) Act 2021**), or any of its subsidiaries, may dispose of RFR land to any person if the Minister of Health has given notice to the trustees that, in the Minister's opinion, the disposal will achieve, or assist in achieving, Health New Zealand's objectives.

Reserves and Other Lands Disposal Act 2015 (2015 No 84)

Replace the cross-heading above section 18 with:

Health New Zealand

In section 19(1), replace "The Nelson Marlborough District Health Board (the **DHB**)" with "Health New Zealand".

In section 19(2), replace "the DHB" with "Health New Zealand".

Residential Care and Disability Support Services Act 2018 (2018 No 33)

In section 5, repeal the definition of **DHB** and insert in its appropriate alphabetical order:

Health New Zealand has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In section 5, definition of **funder**, replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In section 5, replace definition of **section 86 notice** with:

section 90 notice means a notice—

(a) given under **section 90 of the Pae Ora (Healthy Futures) Act 2021**; and

(b) in respect of the provision of LTR care

In section 5, definition of **service agreement**, replace paragraph (a) with:

(a) entered into between a funder and provider; and

Replace section 13 with:

Residential Care and Disability Support Services Act 2018 (2018 No 33)—*continued*

13 Funding eligible

A person is funding eligible if the person belongs to a class of eligible people specified in regulations made under **section 97 of the Pae Ora (Healthy Futures) Act 2021** or is eligible under a ministerial direction continued under **clause 24 of Schedule 1** of that Act.

In section 27(3), replace "A DHB" with "Health New Zealand".

In section 29(1), replace "A DHB that" with "If Health New Zealand".

In section 29(3)(c), replace "the DHB" with "Health New Zealand".

In section 30(1), replace "A DHB" with "Health New Zealand".

In section 30(2), replace "The DHB" with "Health New Zealand".

In section 59(1)(a), replace "a DHB" with "Health New Zealand".

In section 59(1)(c)(ii), replace "section 92(3) of the New Zealand Public Health and Disability Act 2000" with "**section 97(1) of the Pae Ora (Healthy Futures) Act 2021**".

In section 59(2)(b), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In section 65, replace "the applicable DHB" with "Health New Zealand".

Smokefree Environments and Regulated Products Act 1990 (1990 No 108)

In section 91(1)(a), replace "a District Health Board under the New Zealand Public Health and Disability Act 2000" with "Health New Zealand established by the Pae Ora (Healthy Futures) Act **2021**".

Social Security Act 2018 (2018 No 32)

In section 67(d)(i), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In section 72(2)(d)(i), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In section 86(b)(ii), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In section 96(2)(a), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In section 96(2)(b), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In section 402(b), replace "section 92(3)(d) of the New Zealand Public Health and Disability Act 2000" with "**section 97(1)(k) of the Pae Ora (Healthy Futures) Act 2021**".

In Schedule 2, definition of **hospital**, replace paragraph (b) with:

Social Security Act 2018 (2018 No 32)—*continued*

(b) in sections 206 and 207, means a hospital operated by Health New Zealand within the meaning of **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In Schedule 2, definition of **residential care services**, paragraph (g), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

Sport and Recreation New Zealand Act 2002 (2002 No 38)

In section 5, definition of **New Zealand health strategy**, replace "section 8(1) of the New Zealand Public Health and Disability Act 2000" with "**section 4 of the Pae Ora (Healthy Futures) Act 2021**".

Support Workers (Pay Equity) Settlements Act 2017 (previously named the Care and Support Workers (Pay Equity) Settlement Act 2017) (2017 No 24)

In section 3(2)(a) and (c), replace "the 20 DHBs" with "the predecessors of Health New Zealand".

In section 5, definition of **care and support services**, paragraph (a)(i), replace "the Ministry of Health, a DHB" with "Health New Zealand, the Māori Health Authority".

In section 5, repeal the definition of **DHB** and insert in its appropriate alphabetical order:

Health New Zealand has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In section 5, definition of **employer**, replace paragraph (a)(iv) with:

(iv) Health New Zealand; but

In section 5, definition of **employer**, replace paragraph (b) with:

(b) does not include a natural person who receives funding directly from ACC, Health New Zealand, or the Māori Health Authority towards the cost of care and support services for the person or a family member of the person.

In section 5, definition of **funder**, replace "Ministry for Children, a DHB, or ACC" with "Ministry for Children, Health New Zealand, the Māori Health Authority, or ACC".

Veterans' Support Act 2014 (2014 No 56)

In section 107(b), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

Victims' Rights Act 2002 (2002 No 39)

Replace section 11(2)(b) with:

Victims' Rights Act 2002 (2002 No 39)—*continued*

(b) Health New Zealand (as defined in **section 4 of the Pae Ora (Healthy Futures) Act 2021**):

Part 2
Amendments to legislative instruments

Accident Compensation (Ancillary Services) Regulations 2002 (SR 2002/13)

In regulation 6(b)(i), replace "a district health board or other person under an agreement (if any) in force under the New Zealand Public Health and Disability Act 2000" with "Health New Zealand or other person under an agreement (if any) in force under the Pae Ora (Healthy Futures) Act **2021**".

Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 (SR 2003/388)

In regulation 3, definition of **community services card**, paragraph (b), replace "section 92(3) of the New Zealand Public Health and Disability Act 2000" with "**section 97(1) of the Pae Ora (Healthy Futures) Act 2021**".

In section 13(5)(a), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In regulation 18(5)(a) and (6)(c), replace "a district health board" with "Health New Zealand".

COVID-19 Public Health Response (Required Testing) Order 2020 (LI 2020/230)

In Schedule 2, table, item 3.3, replace "district health board" with "Health New Zealand".

Cremation Regulations 1973 (SR 1973/154)

In regulation 7(3), replace "a district health board established by or under section 19 of the New Zealand Public Health and Disability Act 2000" with "Health New Zealand established by the Pae Ora (Healthy Futures) Act **2021**".

Crown Entities (Financial Powers) Regulations 2005 (SR 2005/68)

In regulation 13(1), replace "A district health board" with "Health New Zealand".

In regulation 13(1)(b), replace "as defined in the Crown funding agreement" with "as defined in Health New Zealand's Crown funding agreement".

In regulation 13(4), replace definition of **Crown funding agreement** with:

Crown funding agreement has the same meaning as in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In regulation 13(4), revoke the definition of **district health board** and insert in its appropriate alphabetical order:

Crown Entities (Financial Powers) Regulations 2005 (SR 2005/68)—*continued*

Health New Zealand has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In regulation 13(4), revoke definition of **Residual Health Management Unit**.

Health (Immunisation) Regulations 1995 (SR 1995/304)

In regulation 2(1), definition of **Pharmac**, replace "established by section 46 of the New Zealand Public Health and Disability Act 2000" with "continued by **section 58 of the Pae Ora (Healthy Futures) Act 2021**".

Health (Retention of Health Information) Regulations 1996 (SR 1996/343)

In regulation 2, definition of **service**, replace "section 6(1) of the New Zealand Public Health and Disability Act 2000" with "**section 4 of the Pae Ora (Healthy Futures) Act 2021**".

Health Entitlement Cards Regulations 1993 (SR 1993/169)

In regulation 2(1), definition of **Act**, replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In regulation 2(1), definition of **medical practitioner**, paragraph (d)(iii), replace "section 88 of the New Zealand Public Health and Disability Act 2000" with "**section 90 of the Pae Ora (Healthy Futures) Act 2021**".

In regulation 2(1), definition of **primary health organisation**, replace "a district health board" with "Health New Zealand or the Māori Health Authority".

In regulation 2(1), definition of **provider**, replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In regulation 5(2)(d), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In regulation 8(1)(g), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In regulation 8(3), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In regulation 12(b), replace "any district health board" with "Health New Zealand".

In regulation 12(b)(ii)(A), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In regulation 13(5)(a) and (b), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In regulation 17, definition of **general medical services**, replace "section 25 or 88 of the New Zealand Public Health and Disability Act 2000" with "**section 90 of the Pae Ora (Healthy Futures) Act 2021**".

Health Entitlement Cards Regulations 1993 (SR 1993/169)—*continued*

In regulation 17, definition of **qualifying medical services**, paragraph (a), replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In regulation 20A(b), replace "the Ministry of Health or Health Benefits Limited or any medical practitioner or other health practitioner or any specialist or any pharmacist or any district health board" with "the Ministry of Health or any medical practitioner or other health practitioner or any specialist or any pharmacist or Health New Zealand".

In regulation 22(1), definition of **pharmaceutical**, replace "New Zealand Public Health and Disability Act 2000" with "Pae Ora (Healthy Futures) Act **2021**".

In regulation 22(1), definition of **prescription item**, replace "section 88 of the New Zealand Public Health and Disability Act 2000" with "**section 90 of the Pae Ora (Healthy Futures) Act 2021**".

In regulation 23A(b), replace "the Director-General of Health or Health Benefits Limited or any medical practitioner or any specialist or any pharmacist or any district health board" with "the Director-General or Health or any medical practitioner or any specialist or any pharmacist or Health New Zealand".

Medicines Regulations 1984 (SR 1984/143)

In regulation 2(1), definition of **Pharmac**, replace "section 46 of the New Zealand Public Health and Disability Act 2000" with "**section 60 of the Pae Ora (Healthy Futures) Act 2021**".

In regulation 11(3)(a)(ii), replace "section 6(1) of the New Zealand Public Health and Disability Act 2000" with "**section 4 of the Pae Ora (Healthy Futures) Act 2021**".

National Civil Defence Emergency Management Plan Order 2015 (LI 2015/140)

In the Schedule, clause 2(1), revoke the definition of **DHB** and insert in its appropriate alphabetical order:

> **Health New Zealand** has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In the Schedule, clause 2(1), definition of **PHU**, replace "a DHB" with "Health New Zealand".

In the Schedule, replace clause 47(1)(c) with:

> (c) Health New Zealand, which plans, manages, provides, and purchases services for the New Zealand population, including primary care, public health services, aged care, and services provided by other non-government health providers; and

In the Schedule, clause 50(3), replace "DHBs are" with "Health New Zealand is".

In the Schedule, clause 50(3)(a), delete "within their districts".

National Civil Defence Emergency Management Plan Order 2015 (LI 2015/140) *—continued*

In the Schedule, clause 50(3)(b), delete "affecting their districts, and cooperating with neighbouring DHBs in the development of inter-DHB, sub-regional, regional, and national emergency plans and capability as appropriate to decide how services will be delivered in an emergency (acknowledging DHBs' role as both funders and providers of health and disability service providers, including the provision of support directly or indirectly to other affected parts of the country)".

In the Schedule, clause 50(3)(c), replace "ensuring that all their plans" with "ensuring that all of its plans".

In the Schedule, clause 50(3)(d)(iii), replace "that their own planning" with "that its own planning".

In the Schedule, clause 50(5)(b), replace "relevant DHBs" with "Health New Zealand".

In the Schedule, clause 50(5)(d), replace "DHB regional groups" with "Health New Zealand".

In the Schedule, clause 50(6)(b), replace "the relevant DHBs" with "Health New Zealand".

In the Schedule, clause 50(6)(d), replace "DHB regional groups" with "Health New Zealand".

In the Schedule, clause 51(1), replace "DHBs" with "Health New Zealand".

In the Schedule, clause 51(3), replace "DHBs are responsible for" with "Health New Zealand is responsible for".

In the Schedule, clause 51(3)(c), replace "continuing their services" with "considering its services".

In the Schedule, clause 51(4)(c), replace "coordinating via local DHB" with "coordinating via Health New Zealand".

In the Schedule, clause 51(5)(b), replace "coordinating via local DHB" with "coordinating via Health New Zealand".

In the Schedule, clause 51(6)(b), replace "local DHB" with "Health New Zealand".

In the Schedule, clause 68(6)(a), replace "DHBs" with "Health New Zealand".

In the Schedule, clause 68(6)(h), replace "and DHBs" with "Health New Zealand".

In the Schedule, clause 69(3)(d), replace "with DHBs and primary care and" with "Health New Zealand".

In the Schedule, clause 69(4)(b), replace "DHBs" with "Health New Zealand".

In the Schedule, clause section 71(4), replace "DHBs are responsible for coordinating the provision of psychosocial support services (DHBs advise non-government organisations and primary health organisations on the type and nature of services needed for ongoing psychosocial support)" with "Health New Zealand is responsible for

National Civil Defence Emergency Management Plan Order 2015 (LI 2015/140) *—continued*

coordinating the provision of psychosocial support services (Health New Zealand advises non-government organisations and primary health organisations on the type and nature of services needed for ongoing psychosocial support)".

In the Schedule, clause 71(5)(a), replace "DHBs" with "Health New Zealand".

In the Schedule, clause 72(4)(a), replace "DHBs" with "Health New Zealand".

In the Schedule, clause 73(5), replace "DHBs" with "Health New Zealand".

New Zealand Public Health and Disability (Archives) Regulations 2001 (SR 2001/248)

In regulation 4(a)(i) and (ii), replace "a DHB" with "Health New Zealand or the Māori Health Authority".

Privacy (Information Sharing Agreement between Inland Revenue and Ministry of Social Development) Order 2017 (LI 2017/176)

In clause 3(1), definition of **subsidies**, replace "section 92 of the New Zealand Public Health and Disability Act 2000" with "**section 97 of the Pae Ora (Healthy Futures) Act 2021**".

Privacy (Information Sharing Agreement between New Zealand Gang Intelligence Centre Agencies) Order 2018 (LI 2018/247)

In clause 3, definition of **subsidies**, replace "section 92 of the New Zealand Public Health and Disability Act 2000" with "**section 97 of the Pae Ora (Healthy Futures) Act 2021**".

Public and Community Housing Management (Prescribed Elements of Calculation Mechanism) Regulations 2018 (LI 2018/173)

In regulation 3(1), definition of **Crown**, paragraph (c), replace "(for example, DHBs)" with "(for example, Health New Zealand)".

In regulation 3(1), definition of **Crown**, paragraph (d), replace "a DHB" with "Health New Zealand".

In regulation 3(1), revoke the definition of **DHB** and insert in its appropriate alphabetical order:

> **Health New Zealand** has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In regulation 3(1), definition of **disability support services**, replace "section 6(1) of the New Zealand Public Health and Disability Act 2000" with "**section 4 of the Pae Ora (Healthy Futures) Act 2021**".

In regulation 3(1), definition of **predecessor in title**, replace "a DHB" with "Health New Zealand".

Residential Care and Disability Support Services Regulations 2018 (LI 2018/203)

In Schedule 3, Part 2, clause 2, definition of **Crown**, paragraph (c), replace "(for example, DHBs)" with "(for example, Health New Zealand)".

In Schedule 3, Part 2, clause 2, definition of **Crown**, paragraph (d), replace "a DHB" with "Health New Zealand".

In Schedule 3, Part 2, clause 2, revoke the definition of **DHB** and insert in its appropriate alphabetical order:

> **Health New Zealand** has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In Schedule 3, Part 2, clause 2, definition of **disability support services**, replace "section 6(1) of the New Zealand Public Health and Disability Act 2000" with "**section 4 of the Pae Ora (Healthy Futures) Act 2021**".

In Schedule 3, Part 2, clause 2, definition of **predecessor in title**, replace "a DHB" with "Health New Zealand".

Social Security Regulations 2018 (LI 2018/202)

In regulation 290(2)(d), replace "a district health board" with "Health New Zealand".

In Schedule 8, Part 5, clause 5, definition of **Crown**, paragraph (c), replace "DHBs" with "Health New Zealand".

In Schedule 8, Part 5, clause 5, definition of **Crown**, paragraph (d), replace "a DHB" with "Health New Zealand".

In Schedule 8, Part 5, clause 5, revoke the definition of **DHB** and insert in its appropriate alphabetical order:

> **Health New Zealand** has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In Schedule 8, Part 5, clause 5, definition of **predecessor in title**, replace "a DHB" with "Health New Zealand".

Student Allowances Regulations 1998 (SR 1998/277)

In regulation 2(1), definition of **Crown**, paragraph (c), replace "DHBs" with "Health New Zealand".

In regulation 2(1), definition of **Crown**, paragraph (d), replace "a DHB" with "Health New Zealand".

In regulation 2(1), revoke the definition of **DHB** and insert in its appropriate alphabetical order:

> **Health New Zealand** has the meaning in **section 4 of the Pae Ora (Healthy Futures) Act 2021**

In regulation 2(1), definition of **predecessor in title**, replace "a DHB" with "Health New Zealand".

Part 3
Revocations

Health (Cancellation of Division of District Health Boards into Constituencies) Order 2004 (SR 2004/63)

Health and Disability (Division of Southern DHB into Constituencies) Order 2010 (SR 2010/77)

Health Sector Transfers (Enable New Zealand Limited) Order 2002 (SR 2002/334)

Health Sector (Transfer of Assets and Liabilities of Crown Public Health Limited and CLS Properties Limited) Order 2002 (SR 2002/333)

Health Sector Transfers (Canterbury DHB) Order 2015 (SR 2015/132)

Health Sector Transfers (Christchurch Hospital Hagley Facility) Order 2020 (LI 2020/178)

Health Sector Transfers (Christchurch Hospital Outpatients Facility) Order 2018 (LI 2018/212)

Health Sector Transfers (Hutt DHB) Order 2009 (SR 2009/205)

Health Sector Transfers (NZ Health Partnerships Limited) Order 2015 (SR 2015/148)

Health Sector Transfers (Organ Donation Capability) Order 2020 (LI 2020/188)

Health Sector Transfers (Provider Arrangements) Order 2001 (SR 2001/135)

Health Sector Transfers (Provider Arrangements) Order (No 2) 2001 (SR 2001/247)

Health Sector Transfers (Provider Arrangements) Order 2002 (SR 20021/151)

Health Sector Transfers (Provider Arrangements) Order 2003 (SR 2003/219)

Health Sector Transfers (Southern DHB) Order 2010 (SR 210/79)

Health Sector Transfers (Te Nikau Grey Base Hospital and Health Centre) Order 2020 (LI 2020/148)

Health Sector Transfers (Wellington City Council) Order 2002 (SR 2002/393)

Health Sector Transfers (West Otago Health Trust) Order 2004 (SR 2004/16)

New Zealand Public Health and Disability (Planning) Regulations 2011 (LI 2011/147)

Organ Donors and Related Matters Act 2019 Commencement Order 2020 (LI 2020/192)

Schedule 3
Iwi-Māori partnership boards

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Iwi-Māori partnership board	Area covered by the board (based on territorial authority and ward boundaries as constituted as at 1 January 2001)
Te Kahu o Taonui	Far North District, Whangarei District, Kaipara District North Shore City, Rodney District, Waitakere City Auckland City
Mana Whenua I Taamaki Makaurau / Tainui	Manukau City, Papakura District, Franklin District
Waikato Iwi Māori Council	Hauraki District, Thames-Coromandel District, Waikato District, Waipa District, Hamilton City, South Waikato District, Matamata-Piako District, Otorohanga District, Waitomo District, Ruapehu District (Ohura, Taumarunui and National Park Wards only)
Te Kāhui Oranga	Taupo District, Rotorua District
Te Runanga Hauora o Te Moana a Toi	Tauranga District, Western Bay of Plenty District, Whakatane District, Kawerau District, Opotiki District, Mayor Island (Tuhua), Motiti Island
Te Waiora o Nukutaimemeha	Gisborne District
Te Whare Punanga Korero	New Plymouth District, Stratford District, South Taranaki District
Māori Relationship Board	Wairoa District, Hastings District, Napier City, Central Hawkes Bay District
Hauora a Iwi Relationship Board	Wanganui District, Rangitikei District, Ruapehu District (Waiouru and Waimarino Wards only)
Manawhenua Hauora	Manawatu District, Palmerston North City, Tararua District, Horowhenua District, Kapiti Coast District (Otaki Ward only)
Te Atiawanuitonu Māori Relationship Board	Upper Hutt City, Lower Hutt City
Matanga Toiora Māori Partnership Board	Kapiti Coast District (Paraparaumu, Waikanae and Paekakariki-Raumati Wards only), Porirua City, Wellington City
Te Iwi Kainga Māori Partnership Board	Masterton District, Carterton District, South Wairarapa District
Iwi Relationship Board	Tasman District, Nelson City, Marlborough District
Tatau Pounamu Manawhenua Advisory Group	Buller District, Grey District, Westland District
Iwi Relationship Board: Manawhenua ki Waitaha	Kaikoura District, Hurunui District, Waimakariri District, Banks Peninsula District, Selwyn District, Christchurch City, Ashburton District, Chatham Islands Territory
Māori advisory committee	Timaru District, Mackenzie District, Waimate District
Te Hauora o Murihiku me Araiteuru	Waitaki District, Central Otago District, Dunedin City, Clutha District, Southland District, Gore District, Invercargill City, Queenstown-Lakes District

Schedule 4
Provisions applying to mortality review committees

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1 Interpretation

In this schedule, unless the context otherwise requires,—

document has the same meaning as in section 2(1) of the Official Information Act 1982

judicial proceeding means a proceeding that is judicial within the meaning of section 108 of the Crimes Act 1961

ministerial authority means an authority—

(a) given by the Minister under **clause 6(1)**; and

(b) in force for the time being

serious offence means an offence punishable by imprisonment for a term of 2 years or more.

Compare: 1995 No 95 s 66

Chairperson may require person to give information

2 Chairperson may require person to give information

(1) If a mortality review committee gives its chairperson, or an agent the committee appoints for the purpose, authority in writing to do so, the chairperson or agent may, by notice in writing to any person, require the person to give the committee information in the person's possession, or under the person's control, and relevant to the performance by the committee of any of its functions.

(2) A mortality review committee may authorise it

(3) Examples of the information the chairperson or agent may require are—

(a) patient records, clinical advice, and related information:

(b) answers to questions posed by the chairperson in the notice, and that the person is able to answer:

(c) information that became known solely as a result of a declared quality assurance activity, within the meaning of Part 6 of the Medical Practitioners Act 1995, or a protected quality assurance activity within the meaning of section 53(1) of the Health Practitioners Competence Assurance Act 2003.

(4) The person must take all reasonable steps to comply with the notice.

Production, disclosure, and recording of information

3 Meaning of information

In **clauses 4 to 6**, **information** means any information—

(a) that is personal information within the meaning of section 7(1) of the Privacy Act 2020; and

(b) that became known to any member or executive officer or agent of a mortality review committee only because of the committee's functions being performed (for example, because it is contained in a document created, and made available to the member or executive officer or agent, only because of those functions being performed), whether or not the performance of those functions is completed.

4 Prohibitions on production, disclosure, and recording of information

(1) A member or executive officer or agent of a mortality review committee must not produce or disclose information to another person or in any judicial proceeding, or make any record of it, unless the production, disclosure, or record, is—

(a) for the purposes of performing the committee's functions; or

(b) in accordance with an exception stated in **clause 5**; or

(c) in accordance with a ministerial authority.

(2) In any judicial proceeding, a member or executive officer or agent of a mortality review committee must not be required to produce information in contravention of **subclause (1)**.

Compare: 1995 No 95 s 70

5 Exceptions to prohibitions

Clause 4 does not prohibit—

(a) the production, disclosure, or recording of information if the information does not identify, either expressly or by implication, any particular individual:

(b) the disclosure of information—

(i) with the consent of every person who would be directly or indirectly identified by the disclosure:

(ii) to the Minister, or a person authorised by the Minister, for the purpose of enabling the Minister to decide whether or not to issue a ministerial authority:

(iii) for the purposes of the prosecution of an offence against **section 18(7)** (disclosure of information contrary to this schedule).

Compare: 1995 No 95 s 71

6 Minister may authorise disclosure of information

(1) If the Minister is satisfied that information relates to conduct (whenever occurring) that constitutes or may constitute a serious offence, the Minister may, by notice in writing signed by the Minister, give a ministerial authority authorising

the disclosure of the information, in the manner, and subject to any conditions, specified in the notice, for 1 or more of the following purposes:

(a) for the purposes of the investigation and prosecution of offences:

(b) for the purposes of a Royal Commission, or a commission of inquiry appointed by an Order in Council made under the Commissions of Inquiry Act 1908:

(c) for the purposes of an inquiry to which section 6 of the Inquiries Act 2013 applies.

(2) However, a ministerial authority may be given for information of a non-factual nature (for example, expressions of opinion) only if that information consists only of matter contained in a report or advice prepared by the mortality review committee.

(3) The Minister may at any time—

(a) revoke a ministerial authority; or

(b) revoke, amend, or add to any condition or conditions to which a ministerial authority is subject.

(4) A ministerial authority authorising the disclosure of information does not of itself—

(a) require the disclosure of that information; or

(b) create a duty to disclose that information.

Compare: 1995 No 95 s 72

Supplementary procedure

7 Supplementary procedure

A mortality review committee may regulate its procedure, at its meetings and otherwise, in any manner not inconsistent with this Act it thinks fit.

Schedule 5
Provisions relating to imposition and payment of Ministry levies

ss 96, 97

1 Interpretation

(1) In this schedule, unless the context otherwise requires,—

aggregate expenditure figure, in relation to any financial year, means the aggregate expenditure figure assessed in respect of that year by the Minister under **clause 2(1)**

aggregate levy figure, in relation to any financial year, means the aggregate levy figure determined in respect of that year by the Minister under **clause 2(2)**

beer means the product of the alcoholic fermentation by yeast of liquid derived from a mash of drinking water and malt grains with hops or their extracts that on analysis is found to contain more than 1.15% volume of alcohol

class of alcohol means a class of alcohol as identified in the table in **Schedule 6**

preceding statistical year means the latest complete period of 12 consecutive months in respect of which, at any material time, the following information is available to the Minister:

(a) the total number of litres of each class of alcohol imported into New Zealand during that period; and

(b) the total number of litres of each class of alcohol manufactured in New Zealand during that period

spirits means ethyl alcohol, whether denatured or not, and any spirituous beverages, including brandy, gin, rum, vodka, whisky, and every other description of spirituous alcohol derived from ethyl alcohol

wine means the product of the complete or partial fermentation of any fruit (including grapes), vegetable, or honey, and—

(a) includes—

(i) cider, perry, and mead; and

(ii) fortified wines such as sherry, port, and fruit or vegetable-based alcohols; but

(b) does not include—

(i) beer or spirits; or

(ii) any alcohol containing no more than 1.15% volume of alcohol

winemaker has the same meaning as in the Wine Act 2003.

(2) For the purposes of **clauses 3 and 5**, where any wine manufactured in New Zealand is sold to another winemaker for blending with other wine, the wine so

sold is deemed to be manufactured by the person who blends it, and not by its original maker.

(3) For the purposes of **clause 3(2)**, the total number of litres of wine manufactured in New Zealand during any statistical year is deemed to be the same as the total number of litres of wine sold by winemakers during that year.

(4) For the purposes of **clauses 5 and 6**, the total number of litres of wine sold in New Zealand during any financial year is deemed to be the same as the total number of litres of wine sold in New Zealand during the preceding statistical year.

(5) For the purposes of **clause 3(2) and Schedule 6**, alcohol that is exported from New Zealand during the preceding statistical year is not to be treated as alcohol that is imported into or manufactured in New Zealand.

2 Minister to assess aggregate expenditure figure and determine aggregate levy figure

(1) For each financial year, the Minister, acting with the concurrence of the Minister of Finance, must assess the aggregate expenditure figure for that year that, in his or her opinion, would be reasonable for the Ministry to expend during that year—

(a) in addressing alcohol-related harm; and

(b) in meeting its operating costs that are attributable to alcohol-related activities.

(2) Having assessed the aggregate expenditure figure for any financial year under **subclause (1)**, the Minister must determine the aggregate levy figure for that year, being an amount equal to the aggregate expenditure figure less the amount that, in his or her opinion, is likely to be received by the Ministry during the financial year by way of interest on money invested by the Ministry or from third party or other revenue.

(3) Nothing in this clause obliges the Ministry to expend in any financial year the whole of its income received in that year, and the Ministry may accumulate any part of its income in any financial year and expend it as it sees fit for any of its purposes in any subsequent financial year.

(4) Despite **subclause (2)**, if the Ministry carries forward any such amount to a subsequent financial year, the Minister may, in determining the aggregate levy figure for that year, take into account the whole or any part of that amount.

3 Minister to determine amounts of levy for each class of alcohol

(1) After assessing the aggregate levy figure for any financial year, the Minister must determine, in accordance with **subclause (2)**, the amounts of the levies payable under **clause 5**, in respect of each class of alcohol, in order to yield an amount equivalent to the aggregate levy figure.

(2) The process for determining the amounts of levy is as follows:

(a) *Step 1*—for each class of alcohol, determine the total number of litres of that class of alcohol that was imported into or manufactured in New Zealand during the preceding statistical year:

(b) *Step 2*—for each class of alcohol, multiply the result of step 1 by the appropriate rate, as set out in the table in **Schedule 6**. This gives the (nominal) total number of litres of alcohol for each class of alcohol:

(c) *Step 3*—for each class of alcohol, divide the number of litres of alcohol for that class by the total number of litres of alcohol for all classes. This gives the proportion of the aggregate levy figure that is to be borne by that class of alcohol in the next financial year:

(d) *Step 4*—for each class of alcohol, multiply the result of step 3 by the aggregate levy figure. This gives the amount of levy to be borne by each class of alcohol in the next financial year:

(e) *Step 5*—for each class of alcohol, divide the result of step 4 by the result of step 1. This gives the amount of levy payable on each litre of alcohol of that class in the next financial year.

(3) If a rate for a class of alcohol is described in the table in **Schedule 6** as a variable rate, the Minister must—

(a) determine the rate to be applied to that class of alcohol; and

(b) in making that determination, use the method for determining variable rates that is described in **Schedule 6**.

4 Rate of levy fixed by Order in Council

(1) The Governor-General may, by Order in Council, fix for the next financial year, by reference to each class of alcohol, the amount of levy payable under **clause 5**.

(2) The amount of levy for each class of alcohol must be as determined by the Minister in accordance with **clause 3(2)**.

(3) If a rate for a class of alcohol is described in the table in **Schedule 6** as a variable rate, the Order in Council must identify the rate determined by the Minister under **clause 3(3)** and used for the purpose of **clause 3(2)**.

(4) An Order in Council made under this clause is secondary legislation (*see* Part 3 of the Legislation Act 2019 for publication requirements).

5 Levies payable by importers and manufacturers of alcohol

(1) In every financial year, a levy of the amount set by Order in Council made under **clause 4** is payable by every person who—

(a) enters for home consumption (as that expression is used in the Customs and Excise Act 2018) any imported alcohol that contains more than 1.15% volume of alcohol; or

(b) manufactures in New Zealand any beer or spirits; or

(c) sells any wine manufactured by that person in New Zealand.

(2) No levy is payable under this Act in respect of any alcohol that is not subject to or is exempt from Customs duty under the Customs and Excise Act 2018.

(3) If any person may be allowed, under the Customs and Excise Act 2018, any drawback in respect of any alcohol, that person may also be allowed a refund of any levy paid by that person under this Act in respect of that alcohol.

(4) In this section, **Customs duty** has the meaning given to the term duty by section 5(1) of the Customs and Excise Act 2018.

6 Payment and collection of levies in respect of beer, wine, and spirits

(1) All levies payable under this Act in respect of any beer, wine, or spirits are payable to the Customs in addition to any duty payable to the Customs in respect of the beer, wine, or spirits under the Customs and Excise Act 2018.

(2) For the purposes of **subclause (1)**, the levies are payable to the Customs at the same time as the excise duty or excise-equivalent duty is payable under the Customs and Excise Act 2018 in respect of the beer, wine, or spirits concerned.

7 Powers of Customs

The powers and authorities of the Customs under the Customs and Excise Act 2018, with any necessary modifications, apply in the same manner to the collection of a levy under this Act as they apply to the collection of duty under that Act.

8 All levies collected to be paid to the Ministry

(1) The Customs must pay to the Ministry all levies received under this Act by the Customs.

(2) This clause is subject to **clause 9**.

9 Crown may be reimbursed for collection of levies

(1) For the purpose of reimbursing the Crown for any expenses incurred by the Customs in collecting any levies under this Act, the Customs may retain any percentage of every levy collected by it that may be determined by the Minister of Finance after consultation with the Ministry.

(2) The amount of any levy retained under **subclause (1)** must not exceed 5% of the amount of the levies collected by the Customs.

(3) The Crown is entitled in every financial year to recover from the Ministry out of the fund any sum in respect of the costs incurred by the Director-General of Health in administering this Act that may be determined by the Minister of Finance after consultation with the Ministry.

Schedule 6
Classes of alcohol and rates for each class

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Class	Legal definition of class	Indicative description	Rate
	Alcohol which, if imported, would be classified within the following tariff items	*Percentage of alcohol by volume in most items in class*	
A	2203.00.12, 2206.00.37, 2208.70.30, 2208.90.62	More than 1.15% but not more than 2.5%	1.5%
B	2203.00.22, 2203.00.31, 2203.00.39, 2206.00.47, 2208.70.40, 2208.90.68	More than 2.5% but not more than 6%	Variable
C	2206.00.57, 2208.70.50, 2208.90.72	More than 6% but not more than 9%	8%
D	2204.10.01, 2204.10.18, 2204.21.18, 2204.22.90, 2204.29.90, 2205.10.19, 2205.10.38, 2205.90.19, 2205.90.38, 2206.00.08, 2206.00.68, 2208.70.60, 2208.90.78	More than 9% but not more than 14%	10%
E	2204.21.13, 2204.22.19, 2204.29.20, 2205.10.12, 2205.10.33, 2205.90.12, 2205.90.33, 2206.00.17, 2206.00.78, 2208.70.71, 2208.90.06, 2208.90.85	More than 14% but not more than 23%	Variable
F	2206.00.28, 2206.00.89, 2208.20.04, 2208.20.08, 2208.20.19, 2208.20.29, 2208.30.04, 2208.30.08, 2208.30.19, 2208.40.04, 2208.40.08, 2208.40.19, 2208.50.04, 2208.50.08, 2208.50.19, 2208.60.19, 2208.60.29, 2208.60.99, 2208.70.80, 2208.90.08, 2208.90.48, 2208.90.97	More than 23%	Variable

Method for determining variable rates

For a given financial year, the variable rate for a class is the average alcohol content by volume of all the alcohol of that class that was imported into or manufactured in New Zealand in the preceding statistical year.

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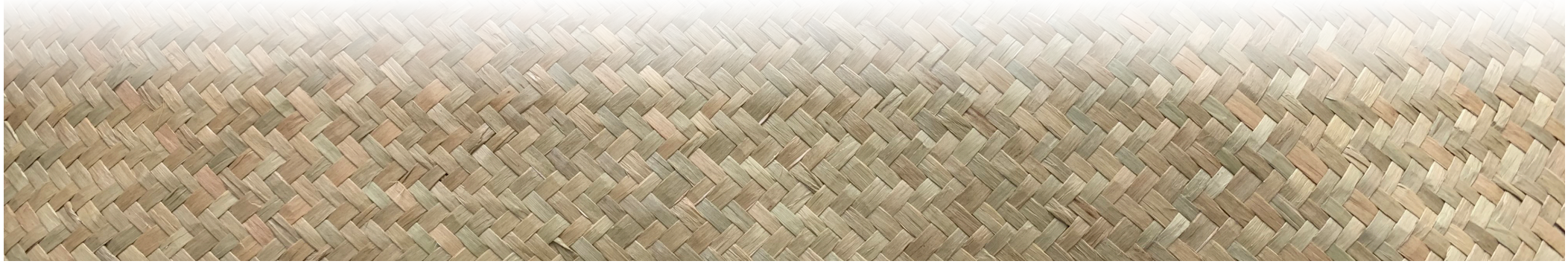
Mana Taurite
Transalpine Workplan FY22

"Te Toia te haumatia"

- nothing can be achieved without a plan and way of doing things -



He Kupu Whakataki (Background/Introduction):

FY22 Mana Taurite Tīma workplan covers te rohe o Waitaha me Tai Poutini (Canterbury and the West Coast). The scope of this transalpine workplan aims to positively influence the achievement of the Ministry of Health's performance measures to improve outcomes for Māori and achieving health equity. The plan is focused on what can be achieved in FY22. A further piece of mahi is required to map out medium and long term, however, this piece will be completed once there is further direction from Health NZ.

1. The Canterbury and West Coast DHB ("DHBs") are committed to Te Tiriti o Waitangi and its principles by ensuring the partnership with Māori are at the forefront of all conversations. The DHBs are also committed to putting people at the heart of all they do, so that they are all supported to deliver world class healthcare to the communities they serve.
2. The DHBs believe that diversity and inclusion is critical to ensure they deliver the best care for the diverse communities they serve. When making decisions they consider and seek a diverse range of viewpoints especially those from minority groups.
3. The Mana Taurite Tīma ("MT") - Rebecca Murchie, Lee Tuki and Akira Le Fevre were appointed in August 2021. A further 1.0FTE has been proposed, 0.5 FTE will be transferred from the Hauora Māori Tīma currently allocated to cultural learning. The other 0.5 is a new resource.
4. MT have been appointed to represent minority communities, with a primary focus to increase the workforce diversity and equity spread proportionately. Our communities:
    a. Māori
    b. Pasifika
    c. Disability
    d. LGBTQIA+
    e. Other minority communities
5. FY22 will primarily focus on developing processes and systems that are targeted at our Māori community. Evaluations of our projects are included in all of our planning. This step will be key to determine how we can apply and adapt the mahi to our other communities.

A process of engagement with a number of key rangatira (leaders), kaimahi (staff) and a review of strategic documents (Tumu Whakarae Position Statement, Whakamaua: Māori Health Action Plan and the Annual Plan Action List) has been undertaken. Three pou have been identified to capture the key focus points for FY22.

Mana Taurite Pou (Equity Pillars):

MANAWA: The three kupu (words) at the heart of MT mahi "Manaaki - Aroha – Awhi"

VISION: Our vision is to bring to life the DHBs' commitment to Te Tiriti o Waitangi and it's principles by ensuring there is partnership with Māori and kaimahi can authentically give effect to these principles.

MISSION: The mahi that is undertaken will provide the DHBs with consistent processes, systems, procedures, materials and resources. Clear expectations and accountabilities will be set.

1. **Whakamanea (Attract)**
   - **a.** Careers website that showcases DHBs as an inclusive employer of choice
   - **b.** Targeted recruitment campaign for entry level career path opportunities

Aroha mai, Aroha atu

- Love toward us, love going out from us.

2. **Kimi Kaimahi (Recruit)**
   - **a.** Robust, inclusive and consistent recruitment processes

He aha te mea nui o te ao? He tangata, he tangata, he tangata

- What is the most important thing in the world? It is people, it is people, it is people.

3. **Pupuru (Retain)**
   - **a.** Calendar of belonging
   - **b.** Mana enhancing cultural practices
   - **c.** Māori Leadership Programme

He kai kei aku ringa

- There is food at the end of my hands.

Mana Taurite Pou (Equity Pillars):

GOAL - MT have set a goal to be a finalist in the 2022 Diversity Awards NZ. MT believe that their commitment to creating a culture of inclusion and belonging will showcase and promote the profile of the DHBs.

BUSINESS AS USUAL (BAU):
Identified areas of work that will be considered as BAU:

- **a.** Representation of our minority communities – steering rōpū, committees, boards.
- **b.** Influence and guide kaimahi to ensure that processes and procedures are robust and inclusive.
- **c.** Apply a diverse and inclusive lens over the mahi undertaken by the Equity, Recruitment and People Partnering.
- **d.** Engage and expand our **influence toward a more inclusive workplace**, including connecting with our communities.
- **e.** Communication standards to weave in te reo Māori and ensuring the language is inclusive.
- **g.** Robust, inclusive and consistent professional development plans that identify career pathways and training opportunities.
- **h.** Hui for our Māori kaimahi during the regular gathering. A chance for our kaimahi to celebrate and be inspired by key note speaker(s) on a Marae.

Ngā Kaupapa Matua (Main Points of Discussion):

A review of Te Tumu Whakarae Position Statement, Whakamaua: Māori Health Action Plan and DHB Annual Plan Action List has been undertaken. Table One (below) are the outcomes that have been identified as MT leading or supporting.

Position Statement by Tumu Whakarae on Māori Workforce - *endorsed by the National DHB Chief Executives March 2019*		
Action to Improve Performance	**Milestone**	**Link to activity**
DHBs will actively grow their Māori workforce to achieve a Māori workforce that reflects the proportionality for their Māori population	DHB will employ a Māori workforce with occupational groupings that reflect the Māori population proportionality for their region by 2040. Report annually	**Whakamanea and Kimi Kaimahi Pou** Data collection: - Base line - Q numbers of Māori successfully gaining employment
DHBs will set in place steps to significantly and meaningfully realise cultural competence for all clinical staff, the Board and other staff groups that have regular contact with patients and whānau.	DHB staff (clinical and non-clinical) who have contact with patients and whānau, Board members and those in people management or leadership roles will demonstrate participation in cultural competence training by 2022.	**Pupuru Pou** Implementation of Mana enhancing cultural practices
	Monitoring measure: DHBs to measure the progress of embedding cultural competency training with the DHBs and monitoring the outcome of this for patients and whānau.	**Kimi Kaimahi Pou** SOA and accountability
All DHBs will measure and report on the recruitment and retention of Māori staff in clinical and non-clinical occupations.	In each DHB, 100% of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview.	Data collection - Apply *internal and external - Interview - Accepted and declined
	In each DHB, turnover for Māori staff will be no greater than the DHB turnover for all staff.	Data collection - Māori resigning - Non- Māori resigning

DHB Annual Plan Action List

Planning Priority: Whakamaua Objective: Shift cultural and social norms / **Planning Priority: Health Workforce** **this is a merge as there was a double up under both headings*

Action to Improve Performance	Milestone	Link to activity
Invest in the development of three new Equity and Diversity focused roles to support the DHB to attract, retain, develop and better utilise our Māori health workforce. (EOA)	**Q1:** Three new roles in place. **Q2-Q4:** Monitoring of recruitment/retention. **Q4:** Increase in the proportion of Māori in the DHB workforce. **Q1:** Three new roles in place. **Q4:** Increase in the proportion of Māori in the DHB workforce. **Q4:** Cultural competency workshops underway	**Q1:** Completed **Q2-Q4:** Implementation of **Attract and Recruitment Pou** **Q4:** Report on the numbers. **Q4: Retain Pou** - Implementation of Mana enhancing cultural practices workstream Data collection: - Base line - Q numbers for Māori successfully gaining employment
Embed the recruitment strategy introduced in 2020/21, to support Māori job applicants, who meet the minimum requirements for positions, to advance to the interview stage, to promote the diversification of our workforce. (EOA)	**Q1:** Pool of Māori to support interviews identified. **Q3:** Impact of policy reviewed. **Q1:** Strategy communicated to hiring managers. **Q4:** Impact of policy change reviewed.	**Q1: Recruitment Pou** – MT available to support interviews. **Q1:** TM support the communication piece if this is something that still needs to be completed. **Q3/4:** Review of the policy added to the **Recruitment Pou** Data collection - Apply *internal and external - Interview - Accept

Planning Priority: Whakamaua Objective: Shift cultural and social norms / **Planning Priority: Health Workforce** **this is a merge as there was a double up under both headings*		
Action to Improve Performance	**Milestone**	**Link to activity**
Working with the Executive Director of Māori and Pacific Health, undertake an evaluation of leadership roles across the DHB to identify opportunities to improve the diversity of representation in decision-making positions. (EOA)	**Q1:** Evaluation completed. **Q2:** Actions to support increase diversity in leadership roles identified. Milestones are the same	**Q2:** MT to review evaluation and look at careers pathways and linking this in with **Retain Pou**
Deliver equity and outcomes training for all new nursing graduates at each Nursing Entry to Practice intake to raise awareness of the differences in health outcomes and ways to improve care for Māori patients and their whānau. (EOA) Introduce a requirement for all nursing graduates to complete the Understanding Bias in Health Care module by the end of their first year of practice. (EOA)	**Q1-Q2:** Equity and outcomes training delivered. **Q4:** All new graduates complete the Understanding Bias in Health Care module. Milestones are the same	**Q1-Q2 :** MT Diversity & Inclusion presentation for NETP/ENSIPP
Build on the collaboration with the University of Otago's Māori/Indigenous Health Institute (MIHI) to rollout the locally designed Hauora Māori Equity Toolkit to departments across the Christchurch campus, as a means of advancing the thinking and skill sets of our staff in responding to the needs of Māori and their whānau in hospital settings and reduce institution barriers to equity. (EOA)	**Q1:** Use of toolkit in Urology evaluated. **Q4:** Number of departments engaged in the use	**Q1:** MT working alongside MIHI to develop the Professional Development Plans that sit within the toolkit. Pupuru pou – co-design to ensure consistency and utilising our resources.

Planning Priority: Health Workforce		
Action to Improve Performance	**Milestone**	**Link to activity**
Engage our leaders in Te Huarahi Hautu, a comprehensive training programme for DHB people leaders, to equip them with the tools to reach their full potential, ensure they model behaviour that reflects our values and vison and build organisational competency in management. Key components are the Health Equity and How We Hire Around Here modules, aimed at upskilling hiring managers in recognising and responding to equity issues and in the technical aspects of the recruitment process to improve diversity in line with the policy above. (EOA)	**Q1:** Te Huarahi Hautu underway. **Q3:** Review of DHB leaders completing the Health Equity and How We Hire modules.	**Q3: Kimi Kaimahi Pou** – reviewing and feeding into the "How We Hire" and "Health Equity" module
Planning Priority: Whakamaua Objective: Strengthen system accountability settings		
Action to Improve Performance	**Milestone**	**Link to activity**
Engage disabled Māori in the refresh of the DHB's Disability Action Plan to promote alignment with Whāia Te Ao Mārama the national Māori Disability Action Plan. (EOA)	**Q2:** Alignment of plans completed.	**MT determine how we can support this alignment and engagement with our disability community*

Figure one is a guiding framework that encourages an inclusive and solution focused approach. We know that with any behaviour and change management process there will be potential barriers that we will need to mirimiri (massage) to get the desired results. It is important to ensure that we are bringing our kaimahi along the journey with us and partner in a mana enhancing way. This has been incorporated in to the project planning and will continue through to implementation. Appendix One have identified key projects for the pou.

Whakapiri
Engaging

To meet and connect with our hauora workforce at all levels of the DHB and potential kaimahi in the community.

Whakamārama
Enlightening

To gain insight on the key issues and barriers. Develop solutions that are strength based and mana enhancing.

Whakamana
Empowering

Implement robust processes and procedures to enhance and empower our hauora workforce and communities. Evaluate for continues improvement.

Vision:	***Have a career website that is inclusive, diverse and relatable to attract a diverse range of medical and non-medical kaimahi***		
Pou Alignment:	*Whakamanea (Attract)*		
Project:	*Careers website that showcases the DHBs as an inclusive employer of choice*		
Assigned Lead:	*Akira Le Fevre*		
Target Audience:	*Talent seeking employment*		
WHAKAPIRI **Engaging**		**WHAKAMĀRAMA** **Enlightening**	**WHAKAMANA** **Empowering**
• *Recruitment Tīma (RT) – build on the current work *te reo, images, stories** • *Kaimahi – diverse range of stories of our kaimahi (nurses' journey)* • *Learning and Development (L&D) – best way to film, photograph and tell the stories of our kaimahi* • *Project SEARCH – include intern stories*		*Showcasing the DHB as an employer of choice* • *Update language to reach all our communities - use of te reo Māori* • *Update the images – range of kaimahi at differing levels of the organisation* • *Upload stories – film, testimonials, photograph* • *Showcasing diverse success stories*	• *Celebrate and encourage our kaimahi to tell their stories.* • *RT to be proud of the website, a reflection on their great mahi* • *Showcasing Māori leadership and diverse kaimahi and their success stories*
Possible constraints / Barriers: • *Challenging to source our kaimahi* • *Kaimahi not available to support with capturing the stories*		***Possible constraints / Barriers:*** • *Deadlines missed* • *Not able to meet with Te Reo Komiti* • *Increasing workload of kaimahi that are already stretched*	***Possible constraints / Barriers:*** • *Communication channels not reaching our target audience*
Success measures: • *Kaimahi feel that their voices have been heard and valued* • *All appropriate kaimahi and communities have been consulted and collaborated with*		***Success measures:*** • *Partnership with internal kaimahi and timelines are met* • *Diverse tangata who may have never seen the DHB as a career opportunity can now see themselves working for the DHB in both medical and non-medical positions*	***Success measures:*** • *Increase in visitors to the website* • *Increase in applications* • *Kaimahi want to tell their stories and be included on the website* • *Varied range of positions filled by diverse tangata*
Timeline: 1-2 month		***Timeline: 1 month***	***Timeline: 1 month***
Partnerships: *Recruitment Team, Learning Development Team, Hauora Māori Leadership, kaimahi, Kia Ora Hauora, Project SEARCH, Nurse Manager (Nursing Website)*			
Date: Timata: *October 2021* ***Mutu:*** *December 2021*			

Vision:	***Breaking down barriers and stigma by creating a pilot recruitment campaign that allocates entry level career path opportunities to Māori and Pasifika school leavers***
Pou Alignment:	*Whakamanea (Attract)*
Project:	*Targeted recruitment campaign for entry level career pathway opportunities*
Assigned Lead:	*Rebecca Murchie*
Target Audience:	*- Māori and Pasifika that are school leavers or are attending bridging courses at alternative institutions (Waitaha)* *- All Māori and Pasifika in te rohe (Tai Poutini)*

WHAKAPIRI **Engaging**	**WHAKAMĀRAMA** **Enlightening**	**WHAKAMANA** **Empowering**
• *Recruitment Tīma (RT) – what has been done in the past and what connections have been developed.* • *Business Partners – workforce planning of entry level positions.* • *Hiring managers (HM) – is a targeted recruitment campaign something that could be adopted for their entry level positions.* • *Target Audience - Tangata whenua, high schools and other alternative institutions.*	• *Confirm opportunities - minimum competency criteria and career path opportunities* • *Develop a robust communication plan to attract kaimahi* **Information day** • *Exercise to identify strengths* • *Present opportunities and allow for time for talent to engage with departments of interest* • *Registration of talent interested and their skill set* **Application process** • *CV, cover letter, referees, application form etc.* • *Review applications and invite to assessment centre* **Assessment centre** • *Short strength-based interview process* • *Provide extra supports to those that are not successful*	• *Support HM to plan and execute their component of the project.* • *Source administration support to manage the event component of the project.* • *Talent have a mana enhancing experience through our recruitment process.* • *Extra support* • *Evaluate by engaging with all partners including the potential kaimahi.* ***Support to successful talent*** • *Induction training session for cohort* • *Tuakana - Tēina relationship* • *On-going monthly check in hui reviewing what is working, areas for improvement, what extra supports are required*

Possible constraints / Barriers: • *Little uptake from departments* • *Little uptake from the communities that we engage with* • *Communication channels not reaching our target audience*	***Possible constraints / Barriers:*** • *COVID-19 outbreak staff redeployed* • *Deadlines missed* • *Increasing workload of kaimahi that are already stretched* *- career pathways are not Identified*	***Possible constraints / Barriers:*** • *Communication channels not reaching our target audience* • *Appropriate venue to deliver sessions not available* • *Cost* • *COVID-19 level restrictions not allowing kanohi ki te kanohi or limited numbers* • *COVID-19 outbreak staff redeployed* *- cohort do not feel support in their roles* *- managers are do not support the career pathways identified*
Success measures: • *Kaimahi and the community partners feel that their voices have been heard and valued*	***Success measures:*** • *Partnership with internal kaimahi and timelines are met* • *Processes are simple, clear and easily adopted*	***Success measures:*** • *Implementation of pilot executed and well attended.* • *We have a significant number of talent attending the assessment day.* • *Continues improvement lens is applied and amendments made where possible* • *Talent report that they have a mana enhancing experience* *- we have a talent pool to keep in the loop for upcoming opportunities*
Timeline: 1-2 month	***Timeline: 3-4 months***	***Timeline: 1 month***
Partnerships: *Recruitment Team, Organisational Development Team, Learning Development Team, Hiring Managers, Hauora Māori Leadership, BP's*		
Date: Timata: *October 2021* ***Mutu:*** *January 2022*		

Vision:	***Recruit a diverse hauora workforce with a focus on increasing Māori and Pasifika kaimahi to better reflect our community that we serve***
Pou Alignment:	*Kimi Kaimahi (Recruit)*
Project:	*Robust, inclusive and consistent recruitment processes*
Assigned Lead:	*Rebecca Murchie*
Target Audience:	*Talent for hauora kaimahi, including: Regulated, Unregulated and Support – an extra emphasis on Māori and Pasifika.*

WHAKAPIRI **Engaging**	**WHAKAMĀRAMA** **Enlightening**	**WHAKAMANA** **Empowering**
• *Recruitment Tīma (RT) – first step will be to seek their feedback on processes that they think could be improved.* • *Organisational Development Tīma (ODT) – attend the 'how we hire' training. Check if there are areas that they want to improve but are not confident (for example Te Tiriti)* • *Hiring managers (HM) – engage a random selection of HMs that have recently hired and seek feedback *training, processes, support** • *Recent applicants – seek feedback on the process *hired and declined**	*Reviewing and feed into the current recruitment processes (RT)* - *max. process including SOA development – is co-design with a community required?* - *Advertising* - *Shortlisting* - *Interviewing – strength based (giving applicants interview Qs, dependent on role)* - *Accept/Decline – providing extra resources, feedback etc* - *Induction* - *Orientation* - *Professional Development Plans* *Review and feed into the 'how to hire training' and "Health Equity" – upskilling our HM to implement mana enhancing cultural practices in to the hiring space*	*Upskilling and implementing new processes and systems* • *RT* • *ODT* • *HR* *Talent have a mana enhancing experience through our recruitment process. Capture at the evaluation and stories for learning.* *Evaluate updated processes and systems at 12 months*
Possible constraints / Barriers: • *Push back from kaimahi* • *Applicants - low numbers wanting to respond on their recruitment journey*	***Possible constraints / Barriers:*** • *Push back from kaimahi* • *Increasing workload of kaimahi that are already stretched*	***Possible constraints / Barriers:*** • *Communication of new process to the organisation* *- misunderstanding of new processes*

Success measures: • *Kaimahi and talent feel that their voices have been heard and valued*	***Success measures:*** • *Processes are simple, clear and easily adopted* • *Training is mana enhancing and true reflection of Te Tiriti* *- we have an increase in Māori applying for positions*	***Success measures:*** • *Implementation* • *Continues improvement lens is applied and amendments made where possible* *- Increase In Māori that accept offers*
Timeline: 1 month	***Timeline: 2-3 months***	***Timeline: 2-3mnts (review at 12 months post implementation)***
Partnerships: *Recruitment Team, Organisational Development Team, Learning Development Team, Hiring Managers, Hauora Māori Leadership*		
Date: Timata: *October 2021* ***Mutu:*** *December 2021 (review at December 2022)*		

Vision:	***Creating a culture of authentic belonging for all our kaimahi***
Pou Alignment:	*Pupuru (Retain)*
Project:	*Calendar of Belonging*
Assigned Lead:	*Akira Le Fevre*
Target Audience:	*All kaimahi*

WHAKAPIRI **Engaging**	**WHAKAMĀRAMA** **Enlightening**	**WHAKAMANA** **Empowering**
• *Minority communities – finding out what is important to them, understanding what is respectful to celebrate and what is appropriate to honour.* • *Communications – ensure that the activities are included and promoted through the different channels.* • *Gathering stats for ethnic and minority groups from the appropriate partners to make sure we are prioritising and targeting the right communities.*	***Suggestions for communities and events we can celebrate/honour:*** • *Te Wiki o Te Reo Māori* • *Pride Week* • *CALD/ESOL* • *Asian minority communities* • *Pasifika communities* • *Trans Awareness Week* • *Te Tiriti o Waitangi* • *Matariki* • *Sign Language Awareness Week* • *Disability Awareness Week* • *Refugee and Immigrant Communities* ***Suggestions for activities:*** • *Quiz – entertaining, relatable and informative* • *Workshops and Training* • *PRISM and max. Knowledge* *- Events Page* *- Something for You* • *Rainbow Breakfast/ Parakuihi* • *Celebrations – stories – people - testimonials*	• *Creating a culture where tangata feel safe to acknowledge and bring their authentic selves to mahi* • *Communicate the calendar to increase kaimahi awareness of activities* • *Creating a culture where tangata feel empowered to not only participate in events but to also get involved in the implementation of events* • *Execute activities (admin support required)* • *Review and evaluate*

Possible constraints / Barriers: • *Kaimahi may not feel comfortable disclosing* • *Knowing the appropriate networks to engage* • *Seeking clarity on what is actually respectful*	***Possible constraints / Barriers:*** • *Availability of external contractors* • *Consent or willingness of talent search* • *Technical/accessibility barrier*	***Possible constraints / Barriers:*** • *Timeframes and overlapping of events* • *Awareness of events*
Success measures: • *Kaimahi feeling seen, visible and safe* • *Kaimahi and community groups proactively seeking out to engage with us and support groups* • *Inclusive and curious discussion happening naturally and safely* • *A happy, productive and diverse workforce*	***Success measures:*** • *Kaimahi addressing unconscious bias* • *Curious and supportive workplace discussions* • *Kaimahi discovering social connections and education about diverse communities* • *Awareness and authenticity.*	***Success measures:*** • *Increased whanaungatanga* • *Kaimahi celebrating diversity* • *Kaimahi knowing each year what events to expect* • *Kaimahi being excited about celebrating and being part of events and being their authentic selves.* • *Kaimahi feeling comfortable to approach the Equity and Diversity Team with unknown or new events* • *Kaimahi being their authentic selves at mahi.* • *Curious discussions in the workplace.* • *DHB having a positive and engaging public profile to those within and outside of the DHB (linkedIn, social media etc)* • *A vibrant and growing Calendar of Belonging.*
Timeline: 1 month	***Timeline: 1 month onwards***	***Timeline: Ongoing***
Partnerships: *Comms team, Executive Leadership Team, Medical Ills, Whaea Pipi, Little Miss Cinnamon, Hector Matthews, Learning and Development, TAM, Facilities (caterers etc), External contractors/educators*		
Date: Timata: *October 2021* ***Mutu:*** *December 2022*		

Vision:	***The Leadership Koru is the waka that brings to life Te Tiriti o Waitangi***
Pou Alignment:	*Pupuru (Retain)*
Project:	*Mana Enhancing Cultural Practices*
Assigned Lead:	*Lee Tuki*
Target Audience:	*Kaimahi katoa*

WHAKAPIRI **Engaging**	**WHAKAMĀRAMA** **Enlightening**	**WHAKAMANA** **Empowering**
• *Engage with DHB kaimahi who are currently delivering the mahi, Organisational Development and key kaimahi* • *Debrief the status of what Is currently being delivered with a focus on the Intended vision, what Is working, the barriers, the cost of these deliveries and who they have been targeted at.* • *Analyse and scope*	• *Design and develop sessions applicable for both DHBs* ** Te Tiriti o Waitangi* ** Te Reo (everyday application, building on current capability)* ** Tikanga (a range of training that applies to different organisational settings)* • *New FTE appointed and supporting this mahi* • *Socialise with Leadership* • *Plan learner journey – online module, kanohi ki te kanohi, resources* • *Begin marketing built into comms plan for both DHBs* • *Pool of Facilitators briefed on the processes and requirements for their area of expertise*	• *Implementation In both DHBs* • *Launch in both DHBs new sessions week beginning Monday 8th February 2022.* • *Shadow facilitators attended sessions to co facilitate* • *Evaluation immediately following the session with follow up evaluations June/July 2022* • *Accountability has been embedded into their IWP, KPI, Team Plans, Professional Development and reporting.*
Possible constraints / Barriers: • *No sessions available to observe and or analyse* • *Conflict of scheduled sessions In both DHB's* • *Regional travel Is halted due to COVID restrictions and or weather* • *Our timeline doesn't align with other organisational timelines* • *Engagement with current facilitators*	***Possible constraints / Barriers:*** • *COVID-19 outbreak could redeploy staff away from BAU* • *Learning and development not available during this timeframe* • *Not able to recruit an appropriate FTE* • *Potential favilitators not available to be trained* • *No sign off to continue* • *Not set up on health learn to register*	***Possible constraints / Barriers:*** • *Marketing misses the mark* • *No facilitator to deliver sessions* • *Appropriate venue to deliver sessions not available* • *COVID-19 level restrictions not allowing kanohi ki te kanohi or limited numbers* • *Staff not released from BAU to attend training* • *No buy in from Leaders to embed accountability into documentations for the kaimahi*

Success measures: • *Attended the current Tikanga and Te Tiriti o Waitangi sessions for both DHBs* • *Engaged with current facilitators and full debrief and overview of their sessions has been completed* • *Input from MT, Learning and Development, Organisational Development and key kaimahi* • *Scoping completed with recommendations for designing and development of sessions* • *Facilitators Identified to be trained to be a pool of facilitators* • *Sign off from both DHB Key Leadership roles*	***Success measures:*** • *FTE appointed* • *No COVID-19 disruptions* • *Design completed* • *Development of sessions, outlines, dates completed* • *Sign off for delivery of new sessions* • *Learner journey opportunities available* • *Preliminary marketing begins, includes socialising the new/redeveloped sessions to generate interest/bookings for 2022 launch* • *Pool of facilitators with expertise in both DHBs have started their training and available to deliver in 2022* • *Train the trainer programme Incorporated Into the sessions for quality assurance, consistency and mentoring to be a stand-alone facilitator to then train others.*	***Success measures:*** • *Full sessions, kaimahi have registered via healthlearn.* • *DHBs have waiting lists to attend sessions* • *Attendance at sessions* • *Facilitators available to deliver session* • *No COVID-19 interruptions* • *Evaluations completed, and feedback incorporated into future sessions* • *Follow up evaluations illustrate kaimahi are bringing to life Te Tiriti o Waitangi in day to day mahi* • *Accountability has been embedded in kaimahi and team documents and planning* • *Requests to run other sessions.*
Timeline: 2 months (October, November 2021)	***Timeline: 2 months (December 2021, January 2022)***	***Timeline: 1 month (February 2022)***
Partnerships: *Learning and Development, Organisational Development, Canterbury and West Coast facilitators, Executive Director of Māori and Pasifika Canterbury and West Coast DHB's, Equity, Recruitment and People Partnering Manager, Key Kaimahi, PRISM kaimahi, Healthlearn, Communications Manager*		
Date: Timata: *October 2021* ***Mutu:*** *March 2022*		

Vision:	***Grow Māori Leadership at all levels***
Pou Alignment:	*Pupuru (Retain)*
Project:	*Māori Leadership Programme*
Assigned Lead:	*Lee Tuki*
Target Audience:	*Māori Kaimahi*

WHAKAPIRI **Engaging**	**WHAKAMĀRAMA** **Enlightening**	**WHAKAMANA** **Empowering**
• *Engage with DHBs to define what Māori Leadership is* • *Engage with identified key Māori kaimahi to scope understanding of Leadership and desire to attend a Māori specific Leadership programme* • *Organisational Development, Learning Development and Mana Taurite teams* • *Identify what is currently being offered regionally, nationally and within our organisation* • *Analyse and scope*	• *DHB Design and develop sessions* • *360 with Te Ao Māori lens built in* • *Identify role models/ mentors / champions for attendees* • *Cultural supervision as a learning component* • *Plan learner journey including pathways after Leadership programme *providing cultural supervision *mentoring other kaimahi, Tuakana / Tēina opportunities for both experience and age* • *Socialise with Canterbury and West Coast Leadership and Te Ao Marama rōpū in both Canterbury and West Coast kaimahi* • *Begin marketing, built into comms plan* • *Facilitators identified and approached to begin preliminary training opportunities*	• *Implementation In both DHB* • *DHB Launches following Tikanga and Te Tiriti o Waitangi sessions in March 2022.* • *Evaluation immediately following each block of the programme and follow up evaluations 3 months after the end of the first programmes*
Possible constraints / Barriers: • *Misunderstanding of Leadership as having direct reports* • *Cost / budgets to attend* • *Belief won't be released or supported to attend so don't consider this as an option* • *Status Quo / Perceptions of Hierarchy* • *Our timeline doesn't align with other organisational timelines*	***Possible constraints / Barriers:*** • *HIdden costs not revealed or know* • *Cost – budget allocation* • *COVID-19 outbreak redeployment of kaimahi involved* • *Learning and development not available during this timeframe* • *No sign off from Canterbury or West Coast Leadership to continue*	***Possible constraints / Barriers:*** • *Marketing misses the mark* • *No facilitators to deliver programme in both DHBs* • *Tangihanga at Marae if this is our venue of delivery* • *COVID-19 level restrictions not allowing kanohi ki te kanohi or limited numbers* • *Kaimahi not released to attend*

• *No facilitators to deliver sessions* • *No buy In from Leadership for their kaimahi to attend or be released to attend*	• *Not set up on health learn to register* • *Push back from Canterbury and West Coast Leadership to free up staff to attend* • *Push back from Māori kaimahi*	• *Weekend time not given back in TOIL to kaimahi* • *Māori kaimahi don't think content is relevant, energising or uplifting* • *No buy in to support accountability lines*
Success measures: • *Engagement with Māori kaimahi in DHBs who are interested in attending a Māori specific Leadership programme* • *Engaged with current facilitators of other Leadership programmes to identified relevant content* • *Input from MT, DHBs, Portfolio Managers, Learning and Development, Organisational Development and key Māori kaimahi* • *Scoping completed with recommendations and cultural lens embedded into the design and development* • *Sign off from Key Leadership roles in both DHBs*	***Success measures:*** • *No COVID-19 disruptions* • *Design completed for both DHBs,* • *Development of sessions, outlines, dates, this includes the train the trainer component for pool facilitators completed for both DHBs* • *Marae/venue confirmed in both DHBs* • *Facilitators secured and trained ready to deliver* • *Trainee Shadow facilitator available to co-facilitate for experience* • *Sign off for delivery of new programme by DHBs Key Leadership* • *Learner journey opportunities available* • *Preliminary marketing begin, includes socialised the new programme to generate interest bookings for 2022 launches In DHBs* • *pool of facilitators confirmed to train and have completed preliminary core training competencies*	***Success measures:*** • *Full sessions in both DHBs, Māori kaimahi have registered via healthlearn* • *Attendance at sessions* • *Culturally appropriate Facilitators available to deliver programme with trainee facilitators cofacilitating* • *No COVID-19 interruptions* • *Evaluations completed, and feedback incorporated into future programmes and development of other programmes i.e. mentoring, supervision* • *Follow up evaluations illustrate Māori kaimahi feel content was relevant, energising and uplifting* • *Māori kaimahi are leading self in day to day mahi* • *Tuakana/Tēina and mentoring pathways have been Implemented* • *A pool of Ō-tama-rākau (brightest Star Shining stars) to develop and nurture* • *Requests to run other Māori programmes and sessions*
Timeline: 2 months (November, November 2021)	***Timeline: 2 months (January, February 2022)***	***Timeline: 1 month (March 2022)***
Partnerships: *Te Ao Marama, Learning and Development, Organisational Development, Executive Director of Māori and Pasifika Canterbury and West Coast DHB's, Equity, Recruitment and People Partnering Manager, Key Kaimahi, Prism kaimahi, Healthlearn, Communications Manager, Marae, Ngāi Tahu*		
Date: Timata: *November 2021* ***Mutu:*** *April 2022*		

West Coast DHB Māori Health Dashboard

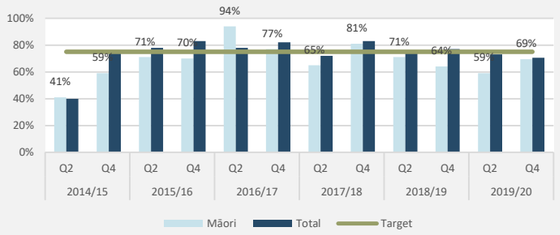
October 2021

Kia whakakotahi te hoe o te waka
WE PADDLE OUR WAKA AS ONE

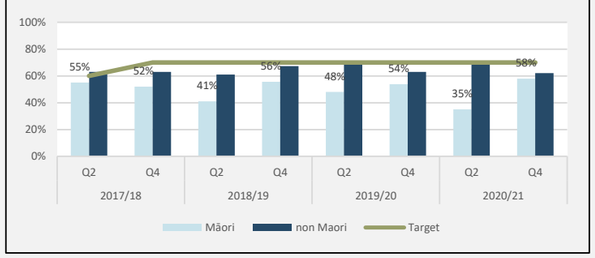
- The target is met for Māori
- The target has not been met for Māori however the trend is improving
- The target has not been met for Māori and performance is decreasing or there is significant inequity

Tamariki Health and Wellbeing

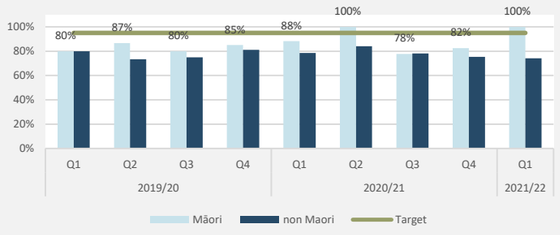
BREASTFEEDING
Percentage of babies exclusive/fully breastfed at LMC discharge



BREASTFEEDING
Percentage of babies exclusive/fully breastfed at 3 months old

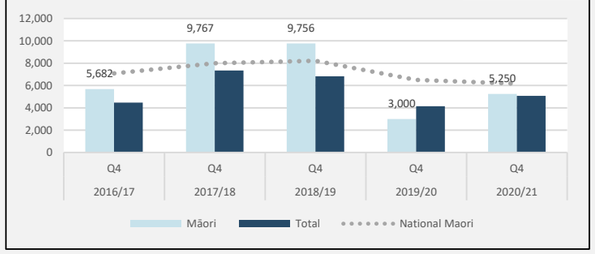


IMMUNISATION
Percentage of 8 month old children fully vaccinated

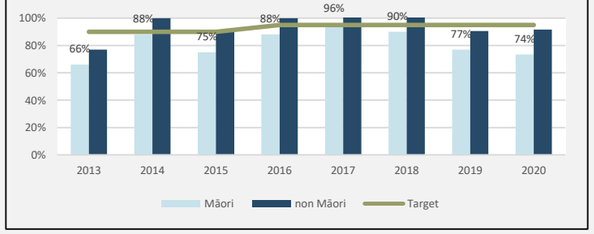


EARLY INTERVENTION
Avoidable Hospital Admissions - Children 0-4 years old

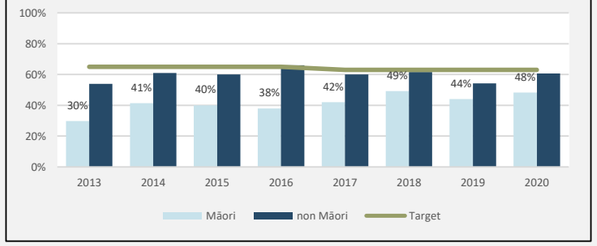
21 Māori Events



ORAL HEALTH
Percentage of pre-school children (aged 0-4 years) enrolled with school and community dental services

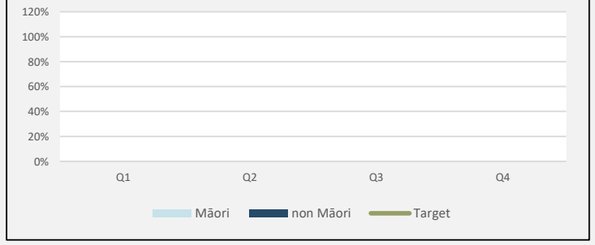


ORAL HEALTH
Percentage of children caries free at age 5 years

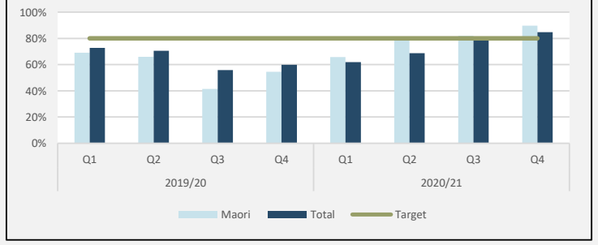


B4SCHOOL CHECK
Percentage of children receiving a B4SC by age 4 years

2021/22

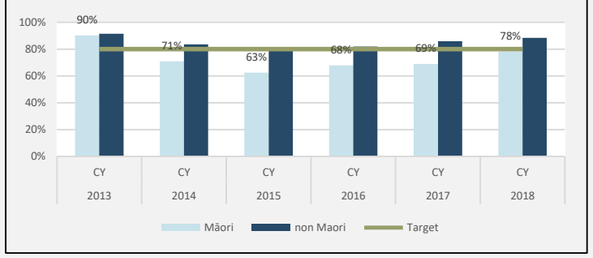


MENTAL HEALTH
Mental Health Clients Under 25 Years-Old Seen Within 3 Weeks

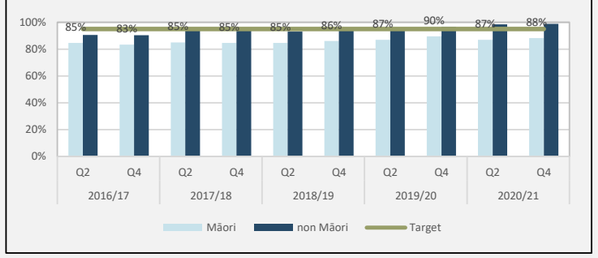


Adult Health and Wellbeing

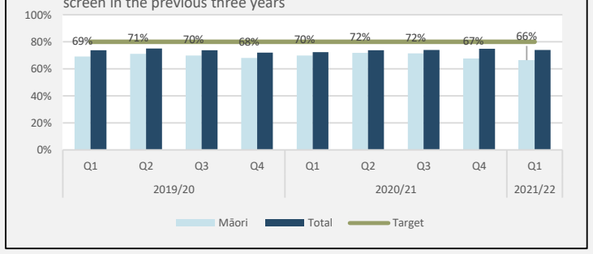
SMOKING
Percentage of women smokefree at two weeks postnatal



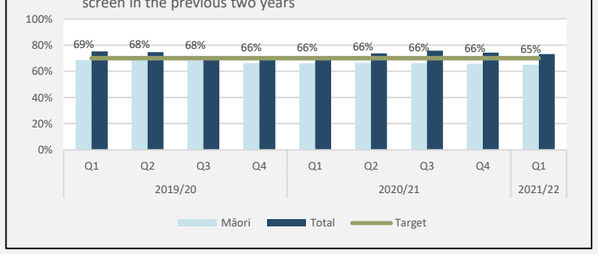
ENGAGEMENT
Percentage of the population enrolled with the PHO



CANCER
Percentage of eligible women aged 25-69 years who had a cervical screen in the previous three years

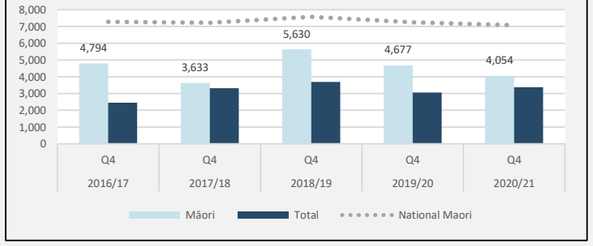


CANCER
Percentage of eligible women aged 45-69 years who had a breast screen in the previous two years



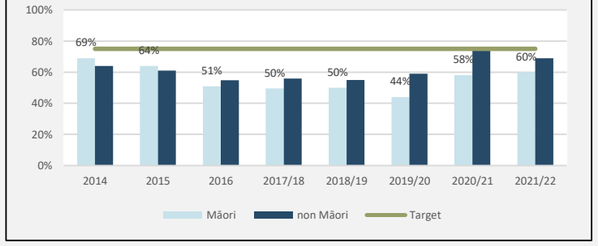
EARLY INTERVENTION
Avoidable Hospital Admissions - Adults 45-64 years old

40 Māori Events



IMMUNISATION - INFLUENZA
Proportion of the population (65+years) who received an influenza vaccination

147 Māori not vaccinated



Indicator Full Name	Data Source	Data Notes
Infants are exclusively or fully breastfed at discharge from LMC	National Maternity Collection (MAT)	Data may be incomplete, excluding data where records have no status
Infants are exclusively or fully breastfed at three months	Well Child Tamariki Ora (WCTO) National Dataset	
Percentage of children caries-free for 5 years	DHB Community Oral Health Services	
Percentage of Infants fully vaccinated at eight months	National Immunisation Register	
Children aged 0-4 years are enrolled with the Community Oral Health Service	Canterbury DHB Community Oral Health Service database "Titanium"	
ASH rates per 100,000 Children 0-4 years old	National Minimum Dataset (NMDS)	ASH data is reported a quarter in arrears
B4SCs are started before children are 4½ years	B4 School Check	B4SC data for quarter one 2021-22 is not currently available from the Ministry of Health . This will be updated next quarter.
Percentage of Women Smokefree at two weeks postnatal	National Maternity Collection (MAT)	This data source has now changed. This measure was using the Well Child reports as its data source, for consistency and continuity of reporting we now use the National Maternity Clinical Indicators report which reports by calendar year.
Population under Mental Health Act: section 29 Community Treatment Orders, rate per 100 000 population	Project for the Integration of Mental Health Data (PRIMHD)	Data is provided 3 months in arrears for each reporting quarter
Women aged 25-69, who have had a cervical smear once in the last three years	National Screening Unit	
Women aged 50-69, who have had a breast screen once in the last two years	National Screening Unit	
ASH rates per 100,000 Children 45-64 years old	National Minimum Dataset (NMDS)	This result was given an orange rating as performance is significantly better than the national result.
Percentage of population (65+years) who have had a seasonal influenza vaccination	National Immunisation Register	This measure has changed from using PHO enrolled population data to census population data. Reporting periods have changed from 12 monthly Jan - Dec to 6 monthly Mar - Sep Results are not directly comparable between 2017 and previous years.
Percentage of the population enrolled with a PHO	PHO Quarterly Report	
Percentage of patients who did not attend their outpatient appointment	DHB data	
Young people <25 accessing specialist mental health services within 3 weeks of referral	PRIMHD (National Mental Health and Addiction data collection)	This is a new measure which has replaced the 0-19 MH and AOD wait times. Data is being reviewed each quarter for accuracy and should be treated with caution