Building our foundations

The foundations of our new health system are to improve equitable health outcomes, embed Te Tiriti, implement a population health approach, drive equity of outcomes and access, and to be a sustainable system.

Health equity matters for everyone

Our drive for health equity is the first foundation of our transformed health system and Te Pae Tata. We aspire to service delivery that gives all New Zealanders the opportunity to achieve good health and wellbeing outcomes, regardless of who they are or where they live. Equity is not only an issue of fairness; it is essential for building an inclusive society and economy where everyone can thrive. Although both equality and equity promote fairness, equality treats everyone the same regardless of need, while equity treats people differently acknowledging their different needs.

The Ministry of Health explains equity as follows:

'In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.'

Despite decades of effort to address inequities, our health system has continued to underserve a number of groups in Aotearoa, including Māori, Pacific people, Tāngata whaikaha | Disabled people, rural communities, those on low incomes, and rainbow and ethnic communities. Inequities experienced by these groups can be demonstrated through differences in life expectancy. For instance, while on average New Zealanders are living longer, life expectancy for Māori is seven years less than non-Māori, six years less for Pacific people and 18-23 years less for people with an intellectual/learning disability.

The variation in service availability across Aotearoa is commonly identified by people as unfair – and is sometimes called a 'postcode lottery'. Where you live can have a direct impact on whether you can reasonably access a health service that can help you. We also know that the type of service available and how it works can also exclude some people. This can be because you need to have a good understanding of the health system to access and complete treatment, or there may be financial, distance, cultural or digital barriers to that care working for you. This means that some people are more likely than others to access health services and complete the care they need.

We will work to improve access to health services that work for our communities. It doesn't mean that every service or type of service must be everywhere, but that people have the ability to access comprehensive care in their community, and emergency and specialist care when they need it.

We will develop Te Ao Māori and Pacific services that reflect the needs of these communities to ensure they can access care in our communities. We will also ensure that Tāngata whaikaha | Disabled people, rural communities, the rainbow community, refugee and migrant communities, and all our communities, have access to services that work for them.

We acknowledge our obligations under the UN Declaration on the Rights of Indigenous Peoples and the UN Convention on the Rights of Persons with Disabilities.

Embedding a Tiriti-dynamic health system

To meet our obligations as Crown agents, we are building a health system that embeds Te Tiriti o Waitangi as its foundation. This means placing Te Tiriti at the forefront of thinking and providing opportunities to enact Te Tiriti principles and articles to improve health outcomes for Māori. It involves changing the way the system functions to address bias and discrimination, balancing leadership between the Crown and Māori communities, sharing decision-making and resources, and making the whole health system accountable for Māori health equity.

Te Aka Whai Ora has specific roles in the system to achieve this, including:

- Working with Te Whatu Ora in the design and delivery of services impacting on Māori health.
- Working with the Ministry of Health and Te Puni Kōkiri to monitor outcomes for Māori.
- Enabling and supporting Iwi Māori Partnership Boards and strengthening the voice of whānau.
- Commissioning Te Ao Māori solutions and services specifically developed with and for Māori.
- Improving service delivery and outcomes with and for Māori at all levels of the health sector.
- Undertaking and promoting public health measures, including commissioning public health programmes.

Waitangi Tribunal *Hauora* Report 2019 and Te Tiriti

The 2019 *Hauora* Report from the Waitangi Tribunal discusses the failings of past attempts to apply Te Tiriti within the health sector. In response, the Waitangi Tribunal recommended that a series of principles be applied to the primary healthcare sector and wider health system.

The actions in Te Pae Tata strive to uphold Te Tiriti o Waitangi. The articles of Te Tiriti provide us with an enduring foundation to our approach and the principles of Te Tiriti, as articulated through the health sector principles in the Pae Ora (Healthy Futures) Act 2022, help to guide our approach.

Overarching examples of how our health reform and the actions in Te Pae Tata embed Te Tiriti o Waitangi articles and principles are outlined below:

NGĀ KUPU O TE TIRITI – ARTICLES OF THE TREATY
Article one: Te Whatu Ora and Te Aka Whai Ora will take responsibility for their respective aspects of good mana whakahaere (governance). This means actively protecting Māori interests and aspirations to secure equitable outcomes for Māori. To do this we will consider Māori world views of health including mātauranga Māori, and take bold action to address discrimination, bias and systemic racism throughout the system.
Article two: We recognise that Māori are unique and indigenous (mana motuhake). The health sector will enable Māori to exercise their authority over Māori health in accordance with Māori philosophies, values and practices. Te Aka Whai Ora will facilitate and resource Iwi and Māori development and, along with Iwi Māori Partnership Boards, they will be equipped to exercise self-determination at all levels of the system.
Article three: We will deliver equitable health outcomes for Māori across the mana tangata (health sector). Te Whatu Ora and Te Aka Whai Ora will enable and support the voice of whānau in the design and delivery of services that are culturally safe and produce equitable outcomes.
Ritenga Māori declaration: We will actively protect and enable Māori cultural identity and mana Māori (integrity). This involves Te Whatu Ora and Te Aka Whai Ora jointly investing to grow the reach of kaupapa providers and Te Ao Māori solutions across our health sector, while also developing the health sector's understanding and application of Te Ao Māori approaches and models. This will give Māori more choice when services are needed and recognises the diversity within Māori society.

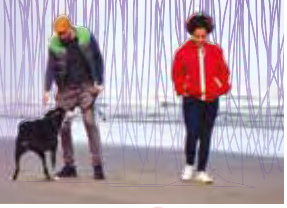
Enacting the principles of Te Tiriti

The health sector principles in the Pae Ora (Healthy Futures) Act 2022 incorporate key outcomes and behaviours from the principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal.

- **We will enable and support Māori** through genuine and meaningful engagement in the design, delivery, and monitoring of health services to reflect their needs and aspirations and improve hauora Māori outcomes.
- **We will be committed to achieving equitable health outcomes for Māori**. This means recognising different approaches and resources better aligned to achieving equitable access to services, levels of service and health outcomes.
- **We will ensure Māori are able to exercise decision-making authority** to gain equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its Māori partners under Te Tiriti are well informed on the extent of efforts to achieve equitable health outcomes for Māori.

- **We will provide for Te Ao Māori health and disability solutions**. Furthermore, the Crown and its agents are obliged to ensure that all health and disability services are delivered in culturally safe and responsive ways that recognise and support the expression of hauora Māori models of care. Te Whatu Ora and Te Aka Whai Ora will work with the health sector agencies and Whaikaha, and be informed by the lived experiences of Māori to continuously improve services and health outcomes for Māori.
- **We will work in partnership with Māori to establish promotional and preventative measures to protect and improve Māori health and wellbeing**, through adopting population health approaches and addressing the wider determinants of health. This includes working collaboratively with other agencies and organisations.

Implementing a population health approach



A population health approach recognises that our health and wellbeing is influenced by many factors that are sometimes outside of our control and often outside the reach of the health system, such as housing quality, employment and income. Our health system will take a population health approach to our collaboration with communities, to work together to plan, design and deliver health services.

The population health approach is well articulated in the Māori concept of pae ora, which highlights the three interrelated components that impact our health and wellbeing:

MAURI ORA

Mauri ora is about healthy individuals and ways of living. To enjoy good health and wellbeing, people need their culture affirmed, a sense of identity and autonomy, and the ability to make healthy choices. This includes the food and drinks we consume, how well we can engage in physical activity, and the impact of alcohol and other drugs on our lives.

WHĀNAU ORA

Whānau ora is about healthy families and ensuring whānau are empowered to thrive, live healthy lifestyles and experience intergenerational wellbeing. This includes a sense of belonging and secure identity, access to good healthcare, housing and education, and being able to confidently participate in society.

WAI ORA

Wai ora is about healthy environments, the ability to engage and the quality of interactions we can have with our surrounding environment. This includes access to safe drinking water, clean air, quality housing, active transport options and being prepared for any emergencies. It also means that we must be good guardians of the land and natural resources.

Working alongside the Public Health Agency, local government and our cross-sector partners, we will shape and influence the environments that impact on people's health and wellbeing, empowering people and whānau to be supported in healthy choices and to pursue healthy lives.

Ensuring a sustainable health service delivery system

The transformation of the health service delivery system to meet the complex demands of our growing and ageing population is underpinned by a premise that a more affordable health system is one that invests in keeping people, their whānau and their communities well and out of hospital. It must address persistent inequities and be nationally-consistent so that health service delivery responds fairly, regardless of who you are and where you live.

The most significant driver of medium- and long-term sustainability will be the shift to models of care and service delivery models that:

- Make better use of interdisciplinary teams, with a greater mix of workforce roles so both the regulated and unregulated workforces collaborate to deliver great care.
- Use digital technologies to simplify care, enable greater self-management and support flexible options for people to access care.
- Ensure joined-up, integrated care within communities to reduce duplication and ensure services are connected for people and whānau when they need them.
- Reflect the population health approach to prevent avoidable illness, and intervene early to reduce the effects and delay the onset of complex health conditions.
- Plan and manage the introduction of new treatments, devices and health technologies.
- Embed a national clinical governance system to improve service quality and safety.
- Implement national and regional networks to drive service consistency.
- Ensure the services we provide reflect the needs of our patients and whānau, meaning we can reduce demand created by failure to intervene early and support whānau in their wellbeing.

It is also establishing a new operating model that will reduce bureaucracy, reduce duplication and avoid waste in health service delivery, and support our healthcare workforce and our communities to build healthy futures.

Section 1:

People and whānau at the heart of health | Ko te pūtake o te ngākau hauora, ko te whānau, ko te tangata

The reason for reforming the health system – and for Te Pae Tata – is to create a more equitable, accessible, cohesive and people-centred system to improve the health and wellbeing of all New Zealanders. This means people will be far more involved than they are today in determining what good care looks like.

We want to build a system that is always thinking about the people and whānau it serves, making sure that the delivery of health services works for them and genuinely improves health outcomes. This requires a high-performing health system where people participate in the design and delivery of care that supports them to live well in their communities. All people – whether they are using, delivering, planning or leading services – are central to this change.

In practice, this means we:

Put people and whānau at the centre, with people having more influence over how we plan and design services, and shape the care available to them locally.

Support our workforce whānau by making healthcare a better place to work, ensuring we have enough people, and the right people, with the right skills in the best places.

Establish inclusive leadership and build a culture of safety that implements Te Mauri o Rongo – The Health Charter.

Use data and intelligence in smarter ways to plan services based on who people are and where they live, and measure the experience of consumers and whānau, to ensure our system is responsive, accessible and equitable.

Te Mauri o Rongo – The Health Charter

Te Whatu Ora and Te Aka Whai Ora developed Te Mauri o Rongo – The Health Charter to guide the culture, values and behaviours of the health sector. It guides how health providers, including Te Whatu Ora and Te Aka Whai Ora, will relate to each other and together serve our whānau and communities to improve health outcomes and build towards pae ora. At the time of publication the Charter is in draft form and due to be consulted through the sector. We will do this in practical ways, including by:

- Caring for the people who care for the people.
- Recognising, supporting and valuing our people and the work we all do.
- Working together to design and deliver services.
- Defining the competencies and behaviours we expect from everyone, especially those in leadership.
- Recognising when things are not working and being responsive to address the problems.

Te Mauri o Rongo – The Health Charter will be the foundation for how we value and harness the voice and expertise of the health workforce to empower them in their work with each other and those they serve. It applies to the whole health sector workforce, including the Ministry of Health, NGOs, the primary and community care sector, and private providers. We are a whānau of five million, a workforce of 240,000 and together we can improve our health and wellbeing.

1.1

Valuing the voices of consumers and whānau

Transformation of health and healthcare requires people to be at the heart of everything that we do, driving the direction of change so that the care we provide enables people to thrive. We will amplify the voices of consumers and whānau to ensure that when we plan and design health services, we have the mechanisms in place to be held to account for acting on people's feedback. People deserve better experiences and outcomes when using health services.

We will ensure we hear the voices of people. We will strengthen the voices of Māori under our obligations to article three of Te Tiriti o Waitangi and listen to the voices of Pacific people and Tāngata whaikaha | Disabled people. There will be simpler ways for all our communities, including migrant, refugee, rural communities, the rainbow community and others to engage with decision-makers at national and regional levels.

Te Whatu Ora will support the Health Quality and Safety Commission (HQSC), the Health and Disability Commissioner, Whaikaha Ministry of Disabled People and the Aged Care Commissioner to ensure appropriate mechanisms exist to hear and respond to consumer voices, including establishing a National Consumer Forum so that the health sector can more easily and consistently engage with diverse communities, along with a Code of Expectations to guide what excellent engagement looks like across Aotearoa.

VALUING THE VOICES OF CONSUMERS AND WHĀNAU ACTIONS
Implement mechanisms that ensure Te Whatu Ora and Te Aka Whai Ora value the voices of consumers and whānau in all service design and improvements: · Establish national consumer leadership network · Measure and publish consumer and whānau experience · Implement people and whānau centred design.
Build on a national Pacific community and lived experience engagement framework to include and embed diverse Pacific voices into the design, delivery and performance of the health system.
Build a platform with Whaikaha | Ministry of Disabled People to include Tāngata whaikaha | Disabled people voices in the design, delivery and performance of the health system.
Build a platform with the Ministry for Ethnic Communities - Te Tari Mātāwaka to include diverse ethnic voices in the design, delivery and performance of the health system.
Build a platform with the Rainbow community to include their voices in the design, delivery and performance of the health system.

1.2

Strengthening workforce whānau

We know our health workforce is highly capable and dedicated. It includes those who are employed by Te Whatu Ora and Te Aka Whai Ora, along with people employed in our provider networks, including private, Iwi Māori, Pacific and NGO providers and charitable organisations.

For many years and particularly through the COVID-19 pandemic, they have worked above and beyond the call of duty to keep New Zealanders healthy and living well. We know our workforce is experiencing increasing strain with many in our workforce feeling tired. Tackling burnout, understaffing and the pressures created by COVID-19 will take time, and we are starting today.

We face challenges in having enough of the right people in the right places at the right time. There is global competition for trained and experienced people, and pressures from shortages contributing to overwork and staff dissatisfaction. Our workforce is aging and we need to find new responses to support our older workforce. These pressures are apparent in many professions, with current acute shortages of general practitioners, medical officers, nurses, midwives and some allied health and technical staff.

We are committed to ensuring that there are appropriate staffing resources to meet demand for the services we provide. This means growing, nurturing and developing a diverse workforce that feels valued and chooses healthcare as a lifelong career. It also means recruiting and retaining appropriate numbers of the right people with the right skills, cultural competence and values aligned with those in Te Mauri o Rongo – The Health Charter, and investing in ongoing professional development. It also means valuing the work of kaimanaaki and kaiāwhina across our system.

A Workforce Taskforce has been established to prioritise a national work programme that addresses barriers to improving workforce pipelines and address critical staffing shortfalls. We have existing workforce strategies, including the Māori Health Workforce Plan and the Ola Manuia | Interim Pacific Health Plan, that we will implement.

Te Whatu Ora and Te Aka Whai Ora begin as new entities committed to partnering with unions to ensure that staff are heard, can feel safe in their workplace, prioritising staff wellbeing and having a workplace free of bullying, racism, fatigue and burnout. Te Pae Tata requires investment in workforce training and development. We will ensure that staff are enabled and feel supported to have a voice and know that they are heard and valued, with more influence in the decisions that affect them. We will develop transformational leadership, with servant leaders who empower and listen to their workforce.

The implementation of Te Mauri o Rongo – The Health Charter is a critical element in building our operating culture to ensure we value the contribution of our workforce. The title 'Te Mauri o Rongo' – 'the Lifeforce of Rongo' refers to Rongo-mā-Tāne the deity of peace and cultivated food.

This name reflects our intention to provide a calm and stable working environment for kaimahi hauora, while recognising that working in health is often complex and emotionally engaging. It guides how leadership and those working in health relate to each other, serving our whānau and communities to continually improve their health outcomes and contribute to pae ora for all. Te Mauri o Rongo – The Health Charter is deliberately grounded in Te Ao Māori and Māori conceptions of leadership; it is intended to respond to the challenge of a Te Tiriti-centred leadership, workforce and health system.

We need our partners to collaborate with us to grow our workforce, partnering across government departments and ministries, professional councils and employee associations, universities, regulatory activities and unions. We also need our education providers, the Ministry of Education and the Tertiary Education Commission to work with us to ensure we are creating the workforce needed to serve our communities.

Finally, we will work with the government direction in pay parity and pay equity.

STRENGTHENING WORKFORCE WHĀNAU ACTIONS
Implement programmes to grow the numbers and diversity of the health workforce, including Māori, Pacific and Tāngata whaikaha | Disabled people, to meet demand by addressing critical workforce gaps as identified by the workforce taskforce.
Implement a workforce pipeline that is informed by intelligence (including a Common Person Number), works with education providers and professional bodies to ensure education and training programmes are in place to grow a quality and diverse healthcare workforce that supports all healthcare providers.
Work in partnership with responsible authorities to standardise professional and regulatory requirements across Te Whatu Ora, Te Aka Whai Ora and ACC to enable registered and unregistered staff to have training and experience pathways to advanced roles and improved interdisciplinary working across urban and rural health services.
Support the Government's planning for future investments in pay equity and pay parity to ensure a fair health workforce environment.
Support educational interventions to increase Māori and Pacific access to health professional training, building the workforce pipeline to grow Te Ao Māori and Pacific services.
Implement and monitor a programme providing nationally consistent cultural safety training to Te Whatu Ora and Te Aka Whai Ora workforces.
Informed by Te Mauri o Rongo | the Health Charter, implement and monitor actions to improve the workplace experience of the healthcare workforce.

1.3

Developing an inclusive leadership and culture

Leadership and culture are critical to the effectiveness and sustainability of our health system. Effective leaders set the tone of an organisation, motivating and supporting others to succeed. They also ensure that the teams they manage or the people they influence are moving towards the same goal: better health and wellbeing for all.

Leadership in the health system will be inclusive, reflecting the diversity of the communities we serve. We will strengthen and grow Māori leadership to ensure Māori are empowered to govern throughout the health system. We will also expand leadership by Pacific people and Tāngata whaikaha | Disabled people to ensure services are accessible and appropriate, with improved outcomes for those underserved by the system.

Our leaders will support a culture that is safe and supportive – one where there is zero tolerance for harassment, discrimination and bullying. This includes appropriate options and support that discourage unacceptable behaviour and encourage people to speak out when needed. Leaders will also support staff to succeed in their job and build a fulfilling career in the health sector. We want our workforce whānau to feel truly valued for the critical role they play in helping people to live longer, healthier and more independent lives.

DEVELOPING AN INCLUSIVE LEADERSHIP AND CULTURE ACTIONS
Increase the number of Māori, Pacific and Tāngata whaikaha | Disabled people in leadership and decision-making roles across the system.
Establish the Pae Ora Leadership Institute to develop our existing and future leaders in health.
Establish Pacific-led regional leadership structures for Pacific health in each region.
Establish a national dedicated Tāngata whaikaha | Disabled people strategic leadership team.

1.4

Strengthening the use of health insights and intelligence

Insights and intelligence data about the people we serve are crucial to keep people and whānau at the centre of service design, delivery and performance. Along with mātauranga Māori and quantitative data, this creates a whole and detailed picture of health service performance and whether people's needs are being met. These data will inform plans to meet service needs as our population grows, ages and becomes increasingly diverse. We will have an evidence base to inform timely decisions around adjustments to health service settings, and to respond to feedback from consumers and whānau.

We currently collect and maintain many datasets about our health system, but we have limited capacity and tools to bring information sources together to draw insights. We also have gaps in our knowledge, particularly in understanding the contributions of primary care and NGOs to health outcomes, along with understanding and measuring people's unmet needs. Developing this understanding is critical to improve health inequities. The Waitangi Tribunal Health Services and Outcomes Inquiry found opportunities for important improvements to the collection, use and availability of data for Māori health.

Our priority is to integrate our information sources to generate insights across the health system, and to understand the voices and feedback from consumers and whānau. We will close our data gaps and continuously improve our data quality. Our system intelligence function will be strengthened across data collection, knowledge synthesis, monitoring and evaluation to optimise responsive decision-making.

Māori sovereignty principles will be embedded in how we manage and use data. Health service organisations will treat health information as taonga/taoka for all groups of people, adhering to the Data Protection and Use Policy along with social service data users across Aotearoa. We will respect and value the people at the centre of our intelligence and insights. The interpretation and use of intelligence about communities will be led and interpreted by those communities, including our Pacific people and Tāngata whaikaha | Disabled people.

STRENGTHENING THE USE OF HEALTH INSIGHTS AND INTELLIGENCE ACTIONS
Establish intelligence and insight leadership that ensures Te Ao Māori, Mātauranga Māori, Pacific and Tāngata Whaikaha | Disabled people's world views are reflected in the use of health intelligence.
Implement a nationally consistent system of data capture, analytics and intelligence that supports the use of health intelligence and insights to ensure equity of access and outcomes from all health services across Aotearoa. This will include: • the Patient Profile and National Health Index to identify Tāngata whaikaha | Disabled people's experience of health, and • Geographic Classification for Health.

Section 2:

Priorities for improving health outcomes and equity | Ngā whakaarotau ki te mana taurite me te whakapiki i ngā putanga hua hauora

Our system will respond to the needs of all New Zealanders, to improve health outcomes and the equity of those outcomes.

One of the primary goals of health reforms is to improve health outcomes and achieve health equity for populations with poorer experiences of health outcomes. Over the next two years, we will drive improved health outcomes and equity by focusing on the areas with the greatest opportunity for health gain, particularly for Māori, Pacific people and Tāngata whaikaha | Disabled people.

Priority areas to improve health outcomes for all, with attention to equity, are:

- **Pae ora** | Better health in our communities.
- **Kahu Taurima** | Maternity and the early years.
- **Mate pukupuku** | People with cancer.
- **Māuiuitanga taumaha** | People living with chronic health conditions such as diabetes, heart disease, respiratory conditions, stroke and gout.
- **Oranga hinengaro** | People living with mental distress, illness and addictions.

We are also prioritising action on climate change to protect the future health of our communities.

These priority areas for health gain are not new; they are areas where inequities continue to persist despite significant effort to shift outcomes for the people who are underserved by the health system.

Over the next two years, changes to structures and settings will support new models of care to achieve equitable health outcomes for all New Zealanders in the priority areas for health gain.

2.1

Pae ora | Better health in our communities

Supporting the healthy futures of the people and whānau we serve is the intention of the Pae Ora legislation. Health and wellbeing, including mental health, is more than the absence of illness; it is the opportunity to live in environments where they can thrive, connected to their communities and their environments. To support our communities, the National Public Health Service and Service Commissioning will work with locality provider networks and communities to support a whānau and community-led approach for improved wellbeing. One that is coordinated and coherent, reflecting their strengths and aspirations.

The good news is that poor health is not a foregone conclusion. The majority (83.5 percent) of health loss in Aotearoa is due to non-infectious disease, with four types of illness accounting for half of this health loss, including cancer, cardiovascular disease, mental ill-health and musculoskeletal disorders. Many of these conditions are potentially preventable.

Strengthening the prevention of illness involves consideration of a broad range of factors that influence people's health. Te Whatu Ora and Te Aka Whai Ora will work with partner agencies to influence improvements in:

- **Physical environment:** Air and water quality, and access to active transport and green spaces.
- **Social and economic environment:** Poverty, education, employment, housing, social connectedness, racism, ableism and ageism.
- **Commercial environment:** Promotion of products and choices detrimental to health, including alcohol, tobacco and unhealthy food.

We are embedding a population health approach to take these factors into account. This will involve implementing the five strategies from the WHO Ottawa Charter for Health Promotion, including to build healthy policy, create supportive environments, strengthen community action, develop whānau, and reorientate health services.

People will live healthier lives when they feel part of an inclusive community, have access to safe, good-quality housing, and are active with good nutrition and emotional support. Achieving improved community wellbeing will involve the leadership of Iwi Māori Partnership Boards, hapū, communities, local government, health and social services, along with other agencies and organisations. Our COVID-19 response demonstrated that communities have the strength and capability to improve health and intervene early to prevent illness. Over the next two years, we will build on these achievements, continuing to adopt a preventive and proactive approach to supporting wellbeing.

We will systematically address the determinants of health, working alongside the Public Health Agency to support a 'health in all policies' approach. Stronger partnerships across a range of agencies will create physical, social and commercial environments that promote health and wellbeing, making the healthy choice the easy choice.

We will take a fresh approach to commissioning services. Our approach aims to support whānau to have access to prevention and early interventions to:

- Empower whānau to take charge of their own wellbeing.
- Ensure that mental health and physical wellbeing are recognised as interdependent.
- Create flexible options for communities to access screening and early intervention services.
- Strengthen providers who work with whānau to support healthy ways of living, along with prevention and early detection of illness.
- Provide outreach services where needed for whānau to access care.

We will need a diversity of delivery models around Aotearoa to respond to the varying needs, strengths and aspirations of local communities and localities. We cannot underestimate the value of local communities' insights and experiences, and we will draw on this expertise to embed a population health approach.

PAE ORA ACTIONS
Implement healthy public policies locally and regionally, to reduce harm from alcohol and other drugs, tobacco, unhealthy foods and obesogenic environments for all communities, with a focus on those with high proportions/ numbers of Māori, Pacific and other groups with inequitable outcomes.
Working with the Mental Health and Wellbeing Commission Locality Plans will support improved mental health and wellbeing and reduced harm from alcohol and drugs in local communities.
Engage with HUD, Kainga Ora, and MSD on options to ensure that people with enduring mental illness and addiction problems can access sustainable housing.
Commission approaches to support greater health and wellbeing making the healthy choices the easy choice for people at risk of chronic conditions and for families raising small children.
Reduce the impact of suicide on communities, including approaches consistent with mātauranga Māori, by accelerating the implementation of the Every Life Matters | He Tapu te Oranga o ia Tangata, Suicide Prevention Action Plan 2019-2024.
BUDGET 21/22 AND GOVERNMENT PRIORITIES
Implement the HIV Action Plan Budget 22.
Implement the Smokefree 2025 Plan with the Public Health Agency.
Implement the Budget 21 expansion of the Healthy Homes initiative.
Develop a national plan to reduce the threat of antimicrobial resistance.
Implement the National Hepatitis C Action Plan for Aotearoa New Zealand.
Ensure national consistency in early support for people and whānau experiencing family harm and violence by connecting them to community providers – Budget 22.

2.2

Kahu Taurima | Maternity and early years

Kahu Taurima will drive the integration of maternity and early years services for a child's first 2,000 days, from conception to five years old, across Aotearoa. These first 2,000 days lay the foundation for a child's entire future; it is a critical period that impacts lifetime health and wellbeing. Mātauranga Māori, along with conventional published evidence, supports investment in and support for the first 2,000 days so every child gets the strongest start to life.

Aotearoa has obligations under the United Nations Convention on the Rights of the Child to ensure basic and fundamental rights for our tamariki. We have more than 60,000 babies born every year and 60,000 opportunities to support a healthier future for them all. Kahu Taurima will focus on our pēpi, tamariki and support for strong, healthy, empowered whānau. It will ensure whānau are well informed about their options and the standard of care they can expect to receive.

Our universal services have supported families through Lead Maternity Carers (LMCs) – mostly midwives and Well Child Tamariki Ora services provided by midwives and NGOs. Over many years, these universal services have been under pressure with little opportunity for change. Increased service fragmentation is seen by patients and whānau as limiting the options to receive the care that best meets their needs.

There is a lack of maternal mental healthcare and whānau with greater needs often feel they do not receive adequate support. For some parents, service fragmentation is made worse by social difficulties such as poor quality housing and family violence.

In these first 2,000 days, the preventable inequity experienced by whānau Māori, Pacific and Tāngata whaikaha | Disabled people is significant. Pregnant Māori women and their pēpi experience poorer service access and outcomes. Pregnant Māori and Pacific people have the highest maternal death rates and are less likely to be cared for by a specialist LMC or obstetrician through most of their pregnancy.

Support for whānau with the greatest needs does not come from the health system alone. At the same time, the Whānau Ora Commissioning Agency and the two place-based initiatives, the South Auckland Social Wellbeing Board and Manaaki Tairāwhiti, have demonstrated that health services can contribute to whānau wellbeing by acting as an engagement point for meaningful support. This is more effective when health services partner with whānau, communities and the social sector to provide flexible, relationship-based, cohesive support across a range of health and social needs and aspirations. It is also important to recognise the expertise of kaumātua and pakeke

in the development and care of the whānau network.

The Kahu Taurima programme of work will take bold steps to change the commissioning of services to support our whānau and materially improve the first 2,000 days of life. We will work with whānau, communities and service providers to design and commission integrated models of care for culturally-appropriate, holistic health and social support for all whānau. These new models of care will be intensified according to need and local aspirations to optimise child development, establishing the building blocks for a positive life course.

KAHU TAURIMA ACTIONS
Redesign the universal model of care, working with LMCs and Well Child Tamariki Ora providers to implement a more flexible and responsive model.
Design and commission Te Ao Māori, whānau-centred and Pacific whānau-centred integrated maternity and early years services.
Redesign community-based oral health services for children so they are responsive to Māori whānau and Pacific aiga to reduce the inequity of access and outcomes.
Ensure national consistency and increased access to urgent oral surgery for children.
Provide education and resources to providers for the care of disabled parents and parents welcoming babies with impairments, aligned with the principles of Enabling Good Lives.
BUDGET 22 AND GOVERNMENT PRIORITIES
Establish maternal mental health and wellbeing pathways of care, including pathways for bereavement and access to specialist mental health services – Budget 22.
Improve access and consistency of access to neonatal retinal screening for premature babies – Budget 22.
Extend the Well Child Tamariki Ora Enhanced Support Pilots as part of these integrated care models – Budget 22.
Support Place based initiatives, including South Auckland and Manaaki Tairāwhiti. Extend the capacity of the health sector, including providers, to participate in place-based, integrated health and social sector services approaches – Budget 22.
Implement the health sector agreements in the Oranga Tamariki Action Plan to improve outcomes for children in their care.

2.3

Mate pukupuku | People with cancer

Each year, around 23,000 people are diagnosed with cancer and 10,000 die from this disease. Cancer is now the leading cause of health loss in Aotearoa, making up 18.5 percent of all health loss. There is significant inequity in cancer outcomes, with around 20 percent more Māori likely to develop cancer and nearly twice as many likely to die compared to non-Māori. Once diagnosed, Māori experience poorer survival than non-Māori for 23 of the 24 most common cancers. Pacific people also experience a higher incidence of and mortality from cancer compared with non-Pacific people. While cancer survival is improving in Aotearoa, our rate of improvement is slower than in other comparable countries and we risk falling behind.

Around 30-50 percent of all cancers are preventable. There are opportunities for cancer prevention strategies to reduce inequity through evidence-based interventions that change the environments in which we live, along with wellbeing interventions that engage Māori and Pacific people.

In December 2019, Te Aho o Te Kahu – Cancer Control Agency, was established to provide national leadership for a stronger, system-wide approach to improve cancer outcomes and address inequities. The vision of Te Aho o Te Kahu is to reduce cancers, improve survival and achieve equitable outcomes for all. It aims to lead a cancer control system that upholds Te Tiriti o Waitangi and provides care that is high-quality, equitable, sustainable and whānau-centred.

Cancer patients and whānau repeatedly describe their cancer journey as distressing and overwhelming, feeling lost and unsupported while navigating a complex medical system. Cancer patients and whānau want customised, holistic, high-quality services that seamlessly support the patient and their whānau through their whole cancer journey. Patients also expect their culture to be acknowledged and its pivotal role in their health understood. This means services that affirm and enhance a person's mana. For this kind of support, we need to focus on the system issues that create inequities, such as the barriers to service access and the variations in treatments offered.

Over the next two years, we will focus on the delivery of equitable care across the cancer continuum, from prevention to palliative end-of-life care and survivorship. The leadership focus will be on addressing unwarranted variations in care, so that everyone can access high-quality cancer care, regardless of who they are or where they live. This includes cancer prevention, improved diagnostic pathways and access to timely best-practice treatment once cancer is diagnosed. Delivery of care will be as close to home as possible, while maintaining safe, high-quality, sustainable services.

In the following actions, we will partner with Te Aho o Te Kahu and Hei Āhuru Mōwai – Māori Cancer Leadership Aotearoa to develop and implement better cancer care for New Zealanders.

MATE PUKUPUKU ACTIONS
Improve Māori and Pacific participation in breast, cervical and bowel screening through targeted approaches with Māori and Pacific community providers.
Develop new, joined-up pathways to facilitate rapid diagnosis of suspected cancer, beginning in primary care to support equitable access to cancer diagnostic and treatment options.
Establish the agreed radiotherapy satellite sites for linear accelerator services (LINAC rollout) to improve people's access to treatment in their communities, and ensure equity of access to radiotherapy.
Implement national pathways to access transport and accommodation to support the equitable completion of cancer treatment.
BUDGET 22 AND GOVERNMENT PRIORITIES
Deliver new equity-focused screening initiatives while sustaining those already developed, including age extension for bowel cancer, HPV self-testing and consideration of lung cancer screening – Budget 22.
Work with Pharmac to support the equitable implementation of new cancer drugs approved for use in Aotearoa.

2.4

Māuiuitanga taumaha | People living with chronic health conditions

One in four New Zealanders lives with multiple chronic health conditions that are often experienced by several generations in the same whānau, such as diabetes, heart disease and stroke. The greatest burden of chronic conditions is experienced by Māori and Pacific people, who develop these conditions 10-20 years earlier than non-Māori and non-Pacific.

Some chronic health conditions create a greater burden of illness for some communities.

Diabetes: An estimated 278,000 people in Aotearoa live with diabetes. While diabetes affects all age groups, around 90 percent of cases are type-2 diabetes which is more prevalent among older age groups. On average, Māori and Pacific people develop type-2 diabetes 10-20 years earlier than New Zealanders of European descent and they experience worse outcomes, including higher rates of limb amputation.

Cardiovascular diseases (CVD): CVD are a group of conditions that affect the heart and blood vessels. CVD are responsible for a third of all mortality and are a leading cause of health loss in Aotearoa. CVD and high blood-pressure affect more than one in five adults and one in two people aged over 40. For half of Māori, Pacific and South Asian people, death from heart disease is premature, occurs earlier than 75 years, and is avoidable.

Respiratory diseases: Respiratory disease is a general term for a complex set of conditions that affect the lungs and respiratory tract. Respiratory diseases account for around 10 percent of hospital admissions and are highly related to poor air quality, such as that caused by smoking, vaping and air pollution. Māori and Pacific children have a high burden of lung conditions arising from cold, damp and mouldy housing.

Stroke: Stroke is the second biggest killer in Aotearoa, accounting for 8.2 percent of all deaths and 4.2 percent of all premature deaths. It is the leading cause of serious impairment in adults. While 25-30 percent of strokes occur in people aged under 65, the incidence increases as people age. Stroke is largely preventable and the number of strokes could be reduced by three quarters.

Gout: Gout is a treatable form of arthritis associated with poor health and reduced life expectancy. Māori and Pacific people are disproportionately affected by gout, in part due to a genetic pre-disposition, yet they often receive sub-optimal care. They are more likely to experience earlier onset of gout and be admitted to hospital for care, with hospitalisation rates five times higher for Māori and 10 times higher for Pacific than for non-Māori and non-Pacific people.

The best way for us to tackle these chronic health conditions is to support people to live healthy lives, reducing the burden and prevalence of these diseases.

To improve treatment for these chronic health conditions, we will ensure our health services will work alongside whānau to improve the health and wellbeing of affected people, and reduce the need for hospital stays that disrupt people's lives.

Given that chronic conditions are responsible for the majority of ill-health in Aotearoa, concentrating on approaches that improve outcomes for a few important conditions is going to be key to making meaningful change over the next two years. The selected conditions with the greatest prevalence and inequities are those described above: diabetes, cardiovascular diseases, respiratory conditions, stroke, and gout.

MĀUIUITANGA TAUMAHA ACTIONS
Implement accessible and nationally-consistent clinical pathways for diabetes, cardiovascular diseases, respiratory conditions, stroke and gout, supporting specialist teams to integrate with primary and community care providers to create seamless pathways for whānau.
Identify and support Māori and Pacific NGOs to work with whānau with chronic conditions to support self-management of their conditions.
BUDGET 22 AND GOVERNMENT PRIORITIES
Develop a Pacific whānau-focused integrated care model for diabetes and implement a dedicated prevention and management programme in South Auckland for Pacific communities – Budget 22.

2.5

Oranga hinengaro | People living with mental distress, illness and addictions

Over 50 percent of New Zealanders will experience mental distress and addiction challenges at some point in their lives, which can impact their ability to build and maintain relationships, care for themselves and whānau, engage in work and participate in society. There is much we can do to support better mental health and wellbeing for New Zealanders and their whānau. This section is only one contribution – the actions outlined across Te Pae Tata to improve health outcomes will all contribute.

Mental health and addiction outcomes for Māori are poor compared to the overall population. Compared to non-Māori, Māori are more likely to experience mental health conditions, receive poorer care, be placed in seclusion, and are less likely to receive pharmaceutical treatment suited to their needs.

There is strong evidence that effective investment in mental health and addiction services positively impacts both people's health and wellbeing and the national economy. Mental ill-health drives economic costs equal to around five percent of gross domestic product (GDP). While some of the financial impact of mental ill-health relates to the direct costs of treatment, more than a third is related to lower employment rates and reduced productivity.

Our current mental health and addiction services are complex and confusing to navigate, so many people do not receive the help they need until it is too late. In 2018, the 'He Ara Oranga' report highlighted the urgent need to transform mental health and addiction services across the full continuum of care. In response, 'Kia Manawanui Aotearoa – Long-term pathway to mental wellbeing' was developed, which is the high-level plan for transformation of services to support the mental wellbeing of New Zealanders.

The scale of change called for in He Ara Oranga and set out in Kia Manawanui is significant, but we are not starting from scratch. The government's response to He Ara Oranga was supported by substantive investment in a cross-government mental wellbeing package. Since the response, we have started building the missing components of our mental health and addiction system, including through enhanced primary-level supports, new kaupapa Māori services, and other population-focused supports, such as specific services for Pacific people, young people and rainbow communities. Mental wellbeing programmes in schools and tertiary institutions are expanding, and we are funding a range of community suicide prevention initiatives and new addiction-focused services. We will build on this momentum as we continue to transform our approach to mental wellbeing.

The COVID-19 pandemic has reinforced the importance of mental wellbeing and resilience around how people adapt to challenging situations. It has highlighted the lack of support currently available for those with enduring mental health conditions. The health system will need to be equipped to address the long-term impact of the pandemic on a community that was already in need prior to the pandemic.

To action Te Tiriti o Waitangi and achieve equitable mental wellbeing for Māori, we will expand Te Ao Māori services to ensure Māori whānau feel supported and engaged in their community and across specialist services. We will focus on better mental health for Pacific people and Tāngata whaikaha | Disabled people, to ensure our services communicate and work with whānau.

We will grow the support services to keep people with serious mental health problems living well in the community, helping people to avoid acute hospital stays where this is appropriate.

This includes partnering with housing services to make sure that people have appropriate accommodation when they are well enough to leave hospital and live in the community. The actions in Te Pae Tata will accelerate the transition between the current and future states, as described in He Ara Oranga (2018) and Kia Manawanui (2021).

Within the hospital and specialist service system, there will be a focus on specialist mental health services. A specialist service network will drive improvements in quality of care, access to care, patient experience and equity of outcomes for specialist mental health services, supported by the National Mental Health System and Services Framework. The framework will identify the core components of a contemporary mental health and addiction system, and guide the development of a national capacity plan for specialist mental health services.

The extensive range of service developments, support for young people, maternal and infant mental health and crisis services reflects the government commitment to He Ara Oranga.

ORANGA HINENGARO ACTIONS
Implement a nationally-consistent approach to the integration of specialist community mental health and addiction teams with NGOs, primary and community care.
Design and expand Te Ao Māori mental health service solutions, including primary mental health and wellbeing, access and choice services.
Urgently progress the mental health inpatient units approved builds and ensure the construction programme meets the agreed milestones.

Develop solutions with communities, including with NZ Police, to support people who are in mental distress or experiencing an acute mental health and addiction episode to access timely care and support.
Work with HUD and MSD in developing solutions with Kainga Ora, housing providers to improve access to quality, safe and affordable housing with support services, to transition people from inpatient mental health units into the community. Continue the He Ara Oranga partnership between police, mental health and addiction services, community groups and Iwi service-providers giving methamphetamine-users the opportunity to get therapeutic help and employment support.
BUDGET 22 AND GOVERNMENT PRIORITIES
Continue the alcohol and other drug treatment courts in Auckland, Waitākere and Waikato – Budget 22.
Continue the rollout of integrated mental health and addiction services in primary care and for young people.
Expand the availability and trial new models of specialist mental health and addiction services for Budget 22, to support the following services: • Child and adolescent mental health and addiction. • Eating disorders. • Taurite specialist Māori.
Continue and expand Mana Ake, a school-based mental health and wellbeing initiative, for primary and intermediate aged children – Budget 22.
Ensure the continuity of Piki, an integrated mental health support initiative for rangatahi – Budget 22.

Section 3:

A unified, smarter, sustainable and equity-led health system | He punaha oranga paiheretia, koi, toitū, a, mana orite

We are re-setting the foundations of our health system to unify health service delivery and deliver joined-up quality care for generations to come.

The last two sections have outlined how our new health service delivery system will be always thinking about the people and whānau it serves to make sure that the delivery of health services works for them, along with an ambitious plan to tackle health outcomes and improve equity of outcomes in six key areas.

This section outlines our plan to improve service delivery in public health, primary and community care, rural healthcare and hospital and specialist services. For service delivery to be sustainable and resilient, we need to consider what is important for each of these areas, while also building on the gains from creating joined-up, integrated services that deliver for people and communities.

The actions and approach outlined below are designed to tackle the problems of today, and to prepare for the challenges of tomorrow. Challenges include increases to investment in health services in response to population growth, ageing and diversity, along with decisions about the adoption of new healthcare technologies and interventions as these continue to improve. We need mechanisms to ensure health services are joined-up and integrated, that adoption of technologies and interventions is evidence-based, resource allocation delivers the best value, and our funding and business models support productive and sustainable health providers.

There are four areas of focus for performance of our unified health system:

- Ensure we have future capability for pandemic responses.
- Support healthy ageing through strong integrated care pathways to prevent unnecessary use of hospitals by our ageing population.
- Provide a continuum of care to ensure we have services to prevent the unnecessary use of hospitals and manage people's flow through our hospitals, and support early, and safe discharge.
- Ensure access to planned care across all settings, within agreed timeframes.

We will strengthen our ongoing COVID-19 response and our future pandemic resilience. The national public health system will provide the leadership, intelligence and capacity to protect our communities.

The three parts of this section include:

MECHANISMS TO DEVELOP A UNIFIED SYSTEM	TRANSFORMING HEALTH SERVICE DELIVERY SUB-SYSTEMS	STRENGTHENING OUR SYSTEM ENABLERS
• Implementing the locality approach • Nationally-consistent strategic networks • Joined-up and integrated pathways of care • Ensuring the quality and safety of our services • Strategic commissioning	• A stronger national public health system • Comprehensive primary and community care services in localities • Accessible rural healthcare • Networked specialist and hospital service delivery creating equitable access to services	• Digital healthcare • Health infrastructure

3.1

Transition to transformation

There are significant opportunities to reduce bureaucracy and unnecessary replication through the shift to a nationally led, regionally managed and locally tailored service. This change will drive value creation, changing how we fund health services and allocate our resources.

In the duration of this plan we will complete transition and merger of entities. By the end of 2024, we will also have positioned Te Whatu Ora to enable the transformation required to achieve the reform's objectives.

This includes:

- Establishing national functions to enable consistency and coordination to get the benefits of standardisation when it matters.
- Strengthening regionally-managed bonds to enable delivery, including community engagement.
- Establishing local hospital networks and localities to engage with communities and be responsive to consumers.

3.1.1 Establishing Te Whatu Ora – Health New Zealand

Over our first two years, we will unify our teams across geographic and professional boundaries, so that our people can work together for the benefit of patients, whānau and communities. This involves setting up new national structures with new leadership roles. The new structures and new ways of working include the following changes:

- Te Whatu Ora will have four regions nationally, known as Northern, Te Manawa Taki, Central and Te Waipounamu. Each region will have functions that operate within our national frameworks to support contract management, analytics and monitoring, and integration planning for primary and community care and hospital services.
- Te Aka Whai Ora will co-locate in regional offices to work in partnership with Te Whatu Ora on strategies and plans for regions and local communities. There will be regional directors for commissioning and for hospital and specialist networks.
- Our new National Public Health Service will bring together the people, abilities, skills and functions from the 12 former public health units, Te Hiringa Hauora – Health Promotion Agency and the Ministry of Health. It will work closely with Te Aka Whai Ora and the Ministry of Health, and in local communities, to embed a population health approach

and to improve people's health outcomes and the equity of health outcomes. Our ongoing COVID-19 work will be integrated with disease surveillance and response management.

- A whole-of-system approach will be used to better manage acute care, respond to winter demand and strengthen after-hours care. National leadership will ensure hospital and specialist services work cohesively across the country. Capacity will be strategically harnessed in public and private hospitals to best meet demand and overcome the significant variations in the quality of care that people experience.
- We will establish localities that draw together our primary and community services to focus on keeping people well in their communities. This will involve creation of comprehensive primary care teams and collaboration with Iwi Māori Partnership Boards, local government and social sector partners. There are over 20 million primary care encounters each year spanning aged care, midwifery, pharmacy, Whānau Ora, mental health, district nursing, allied health, and primary care, delivered by a mix of private, public and NGO entities.

ESTABLISHING TE WHATU ORA ACTIONS

Implements a national, regional and local organisation structure that unifies and simplifies the system using a consistent standardised operating model for corporate functions, including people and culture, finance, commissioning, hospital and specialist, data and digital and infrastructure.

Capture the efficiencies of consolidation to redirect resources to the delivery of healthcare:

- Reduce the overall proportion of expenditure related to management costs and redeploy those savings to front-line staff and services.

3.1.2 Implementing the locality approach

While Te Pae Tata and other national documents will communicate the types of care people can expect to access, the localities approach will enable all New Zealanders to participate in planning and designing these services. Localities are a mechanism that gives effect to Te Tiriti o Waitangi, working with Iwi Māori Partnership Boards to determine the priorities for locality plans. They will afford greater opportunity for mana whenua to uphold their kaitiaki role; and empower Iwi, hapū and whānau Māori alongside wider communities; to shape the care they receive close to home.

Localities will focus on preventing ill-health and helping whānau stay well, giving Iwi Māori and communities a strong voice in identifying their local needs, and getting different health providers working together to improve people's experiences of healthcare.

Local communities, including Iwi Māori, will determine their own geographic area that will become a 'locality'. Localities will be small enough to feel local for the people that live there. Everyone in Aotearoa will fit within a locality that reflects their community.

For each locality, local communities, Te Whatu Ora and Te Aka Whai Ora will work together to create locality plans supported by regional commissioning teams, health intelligence units, public health services, local government and social service organisations. These plans will identify local whānau and community priorities for the design of locality health and wellbeing services and be endorsed by Iwi Māori Partnership Boards.

Within localities we will implement two important mechanisms to support service delivery:

Locality partnerships: Locality partnerships include Iwi Māori, trusted community leaders, health and social sector providers, councils and others. These leaders collaborate with communities, whānau and consumers to deliver three-year locality plans.

Provider networks: Local health providers will be networked together so that people with more complex needs are better able to access different parts of the health system. Provider networks will include service providers, including kaupapa Māori and Pacific providers, working together to deliver better care for whānau regardless of how they first access services.

Localities will be powerful because they will connect services. The healthcare system will feel coherent and connected when they need to access care. This means less re-explaining your medical history when you speak with different providers, easier appointments and referrals, and providers working together to provide wrap-around care. Locality providers will take a whānau-centred approach, starting with what people need rather than the services they usually provide. Pae ora starts in our localities.

The implementation of localities will be phased, using initial prototypes to test elements of the locality approach for populations, and creating a learning environment to inform full implementation across Aotearoa. In phase one, localities will cover approximately nine percent of the population. In 2022-23, phase two will cover an additional 20-30 percent of the population, with phase three completing the rollout across Aotearoa.

The actions we will take to implement localities include:

LOCALITIES ACTIONS
Establish a Localities Learning Collaborative to facilitate learning, including understanding whānau and community experience.
BUDGET 22 AND GOVERNMENT PRIORITIES
Implement the localities model across Aotearoa with locality partnership groups and provider networks to ensure all New Zealanders are part of a locality, with published plans agreed with Iwi Māori Partnership Boards – Budget 22.

3.1.3 Nationally-consistent strategic networks

A priority for these health reforms is the removal of unwarranted variations in access to care, waiting times and clinical practice. Unwarranted variations are inconsistent with fair and equitable access, and safe, effective clinical practice. We will work to ensure that all people, no matter where they live and who they are, receive a comprehensive range of support in their communities, and have access to emergency and specialist care when they need it.

Achieving national consistency depends on evidence-informed leadership, insights from health intelligence, the voices of consumers and experts from a wide range of fields. Internationally and in some parts of Aotearoa, clinical networks within a supportive health system are used to address problems with service delivery. Clinical networks draw clinicians and operational leaders together to identify why gaps occur, evaluate strategic options and adopt solutions to strengthen evidence-based practice, reduce service variation and improve patient outcomes. At present, there are significant gaps and variations to address in clinical networks.

As part of our health system transformation, we will implement networks both nationally and regionally to provide governance to clinical service delivery for complex issues. Networks will be made up of clinicians who bring expertise from different disciplines and different communities including Māori, Pacific, disability and rural consumers with lived experience, and experts including academics and researchers.

There are three types of networks:

National strategic networks: National groups of leaders will drive solutions to complex problems with guidance around improved service performance, health outcomes and equity, in areas like early years and long-term conditions. Expertise will come from across the health and social sector, including consumers, whānau, clinicians and commissioners. These networks will support the adoption of new models of care, technologies and services, reprioritising existing funding where needed. They will actively monitor system and service performance, ensuring services are well configured and planned to accommodate long-term demands.

National service networks: These are service-based networks to drive consistency in delivery of specialist and hospital services. These service networks will ensure that the quality and outcomes of care are consistent across Aotearoa, while recognising that some variance can help tailor care to community needs.

Regional hospital and specialist networks: A regional network will operates as 'one hospital' on many sites. Those in the regional networks will ensure 24-hour by 7-day hospital and specialist services are available and sustainable everywhere. They will minimise unnecessary duplication, clarify referral and discharge pathways, coordinate care, improve quality and reduce waste. They will also oversee collective workforce plans.

STRATEGIC NETWORKS ACTIONS

Establish national strategic networks in the priority areas of:

- Pae ora | Better health in our communities
- Kahu Taurima | Maternity and early years
- Māuiuitanga taumaha | People living with chronic health conditions
- Oranga hinengaro | People living with mental distress, illness and addictions.

Implement national specialist networks to support specialist, planned and urgent care access and outcomes across Aotearoa.

3.1.4 Joined-up and integrated pathways of care

Unifying the health system so that patients move seamlessly through the health system. They feel valued no matter who they are or where they live. Integrated care pathways will support a seamless experience and help to remove unwarranted variation in access and outcomes.

Health pathways are designed to deliver better treatment outcomes for people. A health pathway organises people's care across clinicians and settings, taking account of how local services are arranged and drawing on the best available evidence for clinical practice. It includes guidelines for assessment, investigations, diagnosis, treatment and criteria for referrals. Ideally a well-designed health pathway should be easy for people to understand. There should also be information to support people's understanding of services and how to access them.

Pathways are a powerful tool to promote equity, support more consistent care, and improve efficiency and transparency for both consumers and the health workforce. With pathways documented on shared online platforms, people delivering care can align their practice. Pathway information can also be made available to people to help them understand their own care.

Te Whatu Ora will establish a national platform of programmes and contracts to develop effective health pathways and reduce unwarranted treatment variation across Aotearoa. While national consistency is important, pathways will need to reflect the actual referral and treatment arrangements in local areas so they remain relevant and useful to clinicians. A careful balance is needed in their design.

JOINED-UP AND INTEGRATED PATHWAYS OF CARE ACTIONS

Develop whole-of-system pathways including for prevention, self-care, community and primary care and in hospital settings to achieve nationally-consistent, evidence-based care in the best setting for people and whānau for priority health needs, including:

- Develop health pathways that support equity, incorporating Mātauranga Māori, Te Ao Māori approaches, and integrating whānau perspectives to reduce the burden on whānau to navigate health services, particularly for complex care.
- Standardise pathways across Aotearoa to remove differences in eligibility criteria and access to health pathways, including diagnostics.

3.1.5 Ensuring the quality and safety of our services

Of central importance in the transformation of healthcare is that health services are safe for all people to access and use, and there is a focus on continuous quality improvement.

Thinking about safety in healthcare has changed in recent years, incorporating both traditional clinical safety and wider considerations about how people engage with health services and are affected by their experiences. Understanding the cultural context of care is critical to improving both people's safety and the standard of clinical care they receive. Cultural safety uses patient experience to define the quality of care, allowing people to comment on clinical practices, be involved in decisions about their own care and contribute to their own health outcomes and experiences.

We will focus on standardising the quality of care so that people can be assured that no matter who they are or where they live in Aotearoa, they will be treated well and receive excellent care from any health service provider. Clinical leadership will be a critical part of this change, to ensure that standards of care are based on evidence about best practice, reinforced through strong clinical governance across the system. Quality improvement plans will be developed and implemented to monitor and improve quality, safety and risk through all our service delivery models.

Our partners in quality and safety of service delivery are:

Health Quality & Safety Commission (HQSC): HQSC provides two pivotal roles that support the safety and quality of our health system: monitoring of performance and supporting quality improvement. The latter includes leading local, regional and national quality improvement programmes, supporting the health sector to build capability in quality improvement, and supporting consumer and whānau engagement.

Health Research Council: Research is a core component of a modern, high-performing and equitable health system. We will partner with the Health Research Council, providing intelligence on health, social and clinical needs to help inform how the Health Research Council prioritises funding for health research.

Health and Disability Commissioner: The Health and Disability Commissioner will continue to promote and protect the rights of consumers, providing people with a voice when rights have been breached, resolving complaints and holding providers to account for improving their practices. This includes the Aged Care Commissioner.

Pharmac: Pharmac is responsible for deciding which medicines and related products are funded in New Zealand. We will work with Pharmac to integrate medicines within the broader health system to achieve equitable outcomes, improve timeliness and transparency of decision making, broaden consumer, Māori and Pacific voices in decision making, and incorporate equity considerations in all stages of the assessment processes.

Accident Compensation Corporation (ACC): ACC administers Aotearoa's no-fault accidental injury compensation scheme and helps to prevent injuries from occurring. We will develop stronger partnerships with ACC in the development of safer clinical pathways to improve treatment safety and reduce the impact of injuries. This includes providing non-acute rehabilitation pathways, coordinating services for injured people and improving access to urgent primary care services.

Te Hiringa Mahara – Mental Health and Wellbeing Commission: The Commission's objective is to contribute to better and equitable mental health and wellbeing outcomes for people in New Zealand. We will work with the Commission in their enduring role to transform the approach Aotearoa takes to mental health and wellbeing.

Medsafe: Medsafe is the New Zealand Medicines and Medical Devices Safety Authority. It is a business unit of the Ministry of Health and is the authority responsible for the regulation of therapeutic products in Aotearoa.

The New Zealand Blood Service: The New Zealand Blood Service is responsible for collection of blood and organ donations. It manages the creation of blood products and matching of organ donations, and their supply for emergencies and planned care. It is responsible for the safety of Aotearoa's blood supply.

QUALITY AND SAFETY ACTIONS
Partner with HQSC and clinical leaders across the system to ensure that quality and safety is reflected in performance monitoring, in the delivery of Te Pae Tata and in the delivery of all services.
Partner with ACC to improve road and air ambulance services, increase medication safety and support work in injury prevention, including falls.

3.1.6 **Strategic commissioning**

Strategic commissioning is concerned with understanding our population's need for services, and how best to design services and utilise our resources to meet this need. Te Whatu Ora is ultimately about delivering better health outcomes and equity of outcomes for New Zealanders.

There are several approaches to identify health needs in populations and design services. These include research incorporating voices and feedback from people and whānau, using population-based analytics and other intelligence insights, along with understanding best practice and mātauranga Māori options. Strategic commissioning is grounded in continuous learning and improvement, to adjust and change services appropriately to meet the shifting and unique needs of our populations.

Well-planned strategic commissioning will increase the value and sustainability of the care we provide by making the most effective and efficient use of available resources and strengthening collaboration with our partners and communities, so we improve outcomes and achieve health equity.

Commissioners work with providers and provider networks to ensure delivery of system wide responses to meet population health needs, manage performance and ensure the greatest value for all New Zealanders.

Co-commissioning health services with Te Aka Whai Ora: Given strategic commissioning will make decisions on how resources are allocated and distributed, Te Whatu Ora and Te Aka Whai Ora will agree where they will jointly commission relevant health services to ensure that resources are being used appropriately to meet Te Tiriti o Waitangi obligations and achieve equitable health outcomes.

Sustainable NGO health commissioning: We will work with NGOs who provide a range of community and Aged Care health services to implement integrated and sustainable contracting. This will support eligible contracted providers, to build their capacity to support whānau across a wider range of services. Where there is good performance, we will develop longer-term and more flexible contracts to assist community providers to invest in the workforce and infrastructure they need. This will benefit all community providers, and particularly strengthen Māori and Pacific providers to be successful in their communities.

STRATEGIC COMMISSIONING ACTIONS
Implement a commissioning policy that embeds excellent commissioning practice across Te Whatu Ora and Te Aka Whai Ora.
Develop sustainable and integrated funding arrangements for existing and new Iwi and Māori organisations and Pacific providers reaching 25 percent of eligible providers in the first year and 50 percent in year two.
Implement a programme of pro-equity service planning to inform infrastructure, workforce, digital and transport. This will include regional service planning and individual national specialist service plans in agreed priority areas.

3.2

An enhanced national public health system

Public health is about society's organised efforts to promote health and wellbeing, prevent disease and prolong life for the whole population. This includes work to make our communities and environments places where people are protected from threats, can thrive and stay well.

Public health interventions can have cost-effectiveness ratios better than or equivalent to those of healthcare services. Illustrations include tobacco control initiatives, cardiovascular disease prevention, communicable disease control, and workplace health promotion programmes.

There are opportunities for considerable gains through combining the public health resources and expertise around Aotearoa. Within Te Whatu Ora, we are creating a new National Public Health Service, bringing together the people, abilities, skills and functions from the 12 public health units, Te Hiringa Hauora the Health Promotion Agency, and the Ministry of Health.

Working in partnership with Te Aka Whai Ora and the Ministry of Health, the National Public Health Service will lead in the delivery of public health activities across Aotearoa. It will work closely with regions, localities and community stakeholders to deliver health promotion and prevention, and to build public health capacity and knowledge.

The National Public Health Service will embed the population health approach central to the Pae Ora legislation and the work of Te Whatu Ora and Te Aka Whai Ora.

Through COVID-19, New Zealanders experienced the importance of public health leadership and expertise to manage a pandemic response. The National Public Health Service is a critical part of ongoing and future COVID-19 response. Our pandemic response demonstrated the strength and resilience of our public health system and showed where improvements are needed. A strong public health response is one that is proactive, innovative and connected to our communities. These lessons prepare us for future outbreaks and other threats to public health.

The National Public Health Service will work alongside its national partners and with local communities to deliver public health interventions, consistent with embedding a population health approach to improve health outcomes for New Zealanders and the equity of those outcomes. We will design our services to optimally deliver the five core public health functions through our regions and localities.

The five core functions are:

Health promotion: Collaborating with people and communities to make healthy choices easier.

Health protection: Protecting communities against health hazards like disease outbreaks and environmental threats.

Preventive interventions: Supporting our health system to focus on preventive care to everyone who needs it.

Health assessment and surveillance: Understanding the health needs of populations to help shape how healthcare is planned and delivered to improve health, wellbeing and equity for all.

Public health capacity development: Helping whānau, communities and agencies work together for health in any context.

PUBLIC HEALTH ACTIONS
Establish the National Public Health Service function, embedding Te Tiriti and leading implementation of a population health approach across service commissioning and localities, including working with Iwi Māori Partnership Boards.
Maintain and strengthen robust national surveillance mechanisms for detecting and responding to future communicable disease outbreaks and threats.
BUDGET 22 AND GOVERNMENT PRIORITIES
Develop and agree the investment in data and digital infrastructure to support the establishment of the National Public Health Service – Budget 22.

3.3

Stronger primary and community care

The primary and community healthcare sector is complex and wide-ranging, including services such as aged care, midwifery, pharmacy, Whānau Ora, mental health, district nursing, allied health and primary care. Services are delivered through a mix of private, public and NGO entities with a range of philosophies and models of care, including Te Ao Māori and Pacific providers, and services to support people to age well at home. Every year there are over 20 million consults or other encounters in primary care.

Strengthening primary and community care is one of our opportunities to reduce the risk and burden of disease, reduce demand for more costly and intensive specialist care, and ultimately achieve better and more equitable health and wellbeing outcomes for all New Zealanders. We will work closely with our primary care and community providers to ensure we support what is needed to grow the breadth and depth of services.

We will do this through:

- Implementing a localities approach, including the development of comprehensive primary and community care teams to give people access to a broader range of healthcare in their communities.
- Using information on each localities geographical, social and health needs to target the services required, as well as to monitor their effectiveness in improving health outcomes.
- Working with Iwi Māori Partnership Boards in developing Locality Plans and creating solutions for Māori.
- Changing funding and accountability arrangements to incentivise performance improvement.
- Addressing barriers to access and workforce challenges (see section 1.2).
- Supporting how we provide for unscheduled care.
- Supporting healthy ageing.

Integrated primary and community care within localities

Creation of comprehensive primary and community care teams is a key part of the locality approach, designed to broaden access to health services in the community. In all localities, comprehensive primary and community care teams will be commissioned to deliver high-quality care in accordance with community needs. In some cases, this could mean that you get immediate access to a physiotherapist who works with your primary care provider, and in other cases, it could mean having access to a specialist diabetes nurse.

Funding and accountability arrangements

Te Whatu Ora will transition services from current funding and contracting arrangements, such as primary health organisation and district health board contracts, to a new set of arrangements. New arrangements will include standardised terms and conditions for all primary and community care providers, supplemented with additional funding for specific services. We will support arrangements that bring providers together to support people, whānau and communities. We will reduce unnecessary reporting and bureaucracy.

We will also commission provider network support services to enable quality improvements and information sharing between providers. Standard requirements will include: data-sharing; meeting modern digital standards, including cyber security and interoperability; and working as part of locality provider networks.

Addressing barriers to access

Currently, there is variable access to primary care with one third of New Zealanders aged over 15 years having unmet need for primary healthcare. This can be due to cost, inability to get a timely appointment or time off work, or difficultly finding a local general practice to enrol with.

We will work with providers and communities to address barriers to access and unmet need, for both rural and urban communities. Approaches will include changes to the core funding formula for first-level services, continued investment in the growth and development of Māori and Pacific health providers, and rollout of provider networks and comprehensive primary and community care teams to provide more seamless, integrated care.

(The primary care and community workforce is addressed in section 1.2).

Addressing unscheduled care in primary care

Unscheduled care is any urgent or unplanned healthcare a person needs in a timely manner for an illness or injury. Around 2.5 million New Zealanders visit urgent care clinics each year, there are up to 20 million visits to general practices, and around 1 million visits to hospital emergency departments. As our population grows, ages and diversifies, primary and community care providers must be supported and resourced to meet the growing demand for unscheduled care, so that people can access care as close to home and as soon as possible.

As set out in Te Pae Tata, we will strengthen the management of unscheduled care in several ways to ensure people receive care in the right place, at the right time and from the right person. Included is increased use of telehealth services, improved access to general practitioner appointments on weekends and after-hours, provision of some hospital treatments in community settings where appropriate, and development of better care pathways with ACC and our ambulance services.

Supporting healthy ageing

Increasing the life expectancy for people in Aotearoa is in part a tribute to the success of our health system. Even so, older people who are not well supported in their wellbeing can have an avoidable burden of demand for healthcare. People aged over 65 years require 41 percent of acute medical admissions, 25 percent of emergency department visits, 43 percent of total bed days and 36 percent of general practice consultations.

Our Pae Ora plan for older people and kaumātua continues the work on the Healthy Ageing Strategy 2016-2026. We will pursue alternatives to hospital stays to care for older people who have an urgent health need, or serious health conditions requiring regular treatment.

There are great opportunities through a strengthened and joined-up primary and community sector to support older New Zealanders to live well at home and avoid unnecessary hospital care.

This is critical to ensure older people do not bear an unfair and unnecessary burden of poor health.

Through Te Pae Tata, how we address chronic care, how we respond to urgent care, how our home care support services operate, and aged residential care all contribute to reducing the avoidable burden for older people.

STRONGER PRIMARY AND COMMUNITY CARE ACTIONS
Implement an immunisation and screening catch-up programme including those delivered by Māori and Pacific providers.
Develop a nationally-consistent model for paediatric and adult palliative and end-of-life care that is integrated across primary and community health and strengthens the equitable provision of palliative care across Aotearoa.
Negotiate a community pharmacy services agreement to enable improved integration of clinical services, improvements to access and outcomes, and to drive equity gains.
Prototype admission avoidance, early discharge and home-based care, including remote monitoring pilots; and refocus community nursing, allied health and the Needs Assessment and Service Coordination services to be part of comprehensive primary and community care teams.
Review the aged care, home and community support services models to improve the sustainability of services and ensure equity of access and outcome.

BUDGET 22 AND GOVERNMENT PRIORITIES
Establish comprehensive primary and community care teams within locality provider networks. These will combine traditional primary care services with physiotherapists, pharmacists, care coordinators, advanced paramedics (rural focus), registered social workers and kaiāwhina – Budget 22.
Implement a revised general practice funding model that is responsive to health need and equitable outcomes for Māori and Pacific – Budget 22.
Commission comprehensive primary care models in high Pacific populations that address the needs of the community – Budget 22.
Implement the Payment to Family Members for Support Services for those who choose this option – Budget 22.
Commission comprehensive primary and community care models in high Māori populations that address the needs of the community – Budget 22.
Expand School Based Health Services into activity centres and increase service delivery levels in kura kaupapa for high need students – Budget 22.
Implement the Dementia Mate Wareware Action Plan – Budget 22.
Improve access to primary healthcare services for Transgender Peoples – Budget 22.
Implement services to support health practitioners to provide best practice healthcare to intersex children and young people and to empower intersex children and young people and their whānau to make informed decisions about medical interventions – Budget 22.

3.4

Rural healthcare

Over 700,000 New Zealanders, nearly one in seven, live in rural parts of Aotearoa. This rural population has a greater percentage of children, older people and Māori compared to urban areas. Compared to urban populations, people living rurally, particularly Māori, Pacific and those on lower incomes, face inequitable access to care. Poorer access to health services relates to barriers around costs, socioeconomic deprivation, geography and distance, transport and telecommunication limitations, and the design of services. Access to hospital-level care is particularly affected by distance, travel times and associated costs.

There are different definitions and degrees of rurality, with differing implications for people's access to and experience of health services. Rural areas that are close to urban areas can have better access to services than more remote areas. There are also inequities in health outcomes based on ethnicity, with Māori more likely to reside in rural areas and have higher health needs, along with Tāngata whaikaha | Disabled people who live rurally.

Iwi Māori Partnership Boards will ensure that Te Ao Māori approaches are incorporated into service designs and provide expertise to lead locality approaches and rural models of care. Leadership of Tāngata whaikaha | Disabled people within local planning will also be part of rural approaches.

To ensure service commissioning is appropriate for rural communities, we will engage with the Ministry of Primary Industries, and will embed a 'rural proofing' requirement across our service design and commissioning to ensure rural care is sustainable. We will recognise the strengths and aspirations of rural communities and address barriers for both communities and providers, to provide appropriate access to high-quality care. This includes expanding the use of digital and telehealth services, among our workforce and directly to people receiving care, to increase local access, connectivity and continuity of care. At the same time, we will maintain face-to-face services for people who cannot engage through digital technologies.

RURAL HEALTHCARE ACTIONS
Review the Primary Response in Medical Emergencies model with ACC and develop integrated and responsive rural ambulance programmes to improve access to primary and community care services.
Determine how to scale digital telehealth services to provide rural communities with reliable and sustainable afterhours access. Introduce and expand specialist advice models for virtual consultations with both whānau, and primary and community services providers.
Commission a national telehealth medical and specialist liaison service, with a specific focus to support rural areas and drive equity of access across key populations.
Ensure locality planning in rural areas improves access to healthcare in the most appropriate and sustainable way.

3.5

Networked hospital and specialist service delivery

A key focus of Te Pae Tata is to help people to stay well. But when people are unwell, our system needs to meet their needs with accessible, culturally responsive and high-quality healthcare. As part of our broader system of care, hospital and specialist services are important to restore people's health and improve patient and whānau outcomes.

Demand for hospital and specialist services is growing due to population growth, ageing, increased numbers of people with chronic health conditions, and new technologies that introduce new treatments. We also face increased pressures from the recent COVID-19 outbreaks, along with workforce and infrastructure challenges.

National leadership will ensure hospital and specialist services work cohesively across Aotearoa, making optimal use of capacity to meet demand and improving the consistency of access and outcomes for New Zealanders. They will be supported by nationally-consistent strategic networks (see Section 3.1.2).

At a regional and national level, we will focus on tackling the significant variations that exist in access to and outcomes of care, for various groups. We will simplify access to national and regional specialist services and address unwarranted variation in the quality of care people experience. Quality and outcome metrics with a focus on improving equity will be established for hospital and specialist services.

Our hospital and specialist system will create more sustainable agreements to harness private sector capacity to complement our public system resources. Alongside these tactical solutions, national service planning will ensure our system is future ready. Over the next two years, a rolling programme of work will create a national service plan to drive long-term efficiencies. This will bring together the requirements for national specialist services and regional care, to inform our infrastructure, workforce, digital and transport plans.

The unscheduled care system in Aotearoa is complex and not easy to navigate. There are many places where people can go when they are injured or unwell, and several different health services can be involved in a single episode of care. We need a whole-of-system approach to manage acute care for everyone, particularly as we prepare for winter pressures. Within primary and community care there is a commitment to strengthen telehealth, after-hours general practice, to shift some hospital services to the community where appropriate, and to work better with emergency services.

In this Plan we are taking key actions to build a hospital and specialist system that:

- Drives service change to create national consistency, equity and access to care.
- Provides more equitable and timely access to planned care.
- Delivers high-quality, integrated services for people with urgent care needs.

Reform transport and accommodation support

When services need to be delivered away from home, there is significant variation in the transport and accommodation available to enable access to care. We will focus support on people who are rurally based, those with disabilities and all other people who need to travel to complete treatments, with a priority on the equitable completion of cancer treatment (see action in Section 2.3).

We will ensure that responsive transport and accommodation options are available. This means working in partnership with the emergency road ambulance services, St John and Wellington Free Ambulance, along with the air ambulances. To address pressures, we will ensure they have the capacity to respond to emergencies and to provide a cohesive system, avoiding unwarranted variation in access to care.

Focus on what patients and whānau value and improve their experience of care

Te Whatu Ora will work to provide better coordination and easier navigation of services. A particular focus is where people need to access multiple specialties, care is provided across multiple locations, and between primary care, diagnostic services and specialist care. We will reorientate the hospital system to be more person- and whānau-centric. We will reduce the burden on people to coordinate multiple specialist appointments, and ensure specialist services are more integrated with primary and community care and are more often delivered in community settings.

NETWORKED HOSPITAL AND SPECIALIST SERVICE DELIVERY ACTIONS
Implement the Reset and Restore Planned Care Plan, with demand balanced across sites to maximise delivery to all our communities, utilising all the resources available.
Develop and implement surge planning that utilises regional and community care capacity to maintain safe patient and staff environments.
Develop regional and national production plans by 1 July 2023, to drive delivery of equitable, and greater levels of planned care for the next three years.

Implement regional equity accountability measures, to set clear expectations that specialist and hospital services are responsible for achieving equitable outcomes.
Develop regional booking and scheduling tools, including patient-led bookings to equitably improve the experience of patients and whānau.
Build a sustainable commissioning relationship with the private hospital sector establishing longer term agreements.
BUDGET 22 AND GOVERNMENT PRIORITIES
Ensure emergency air transport is consistently available to all New Zealanders with the required level of infrastructure and resource availability – Budget 22.
Ensure essential emergency road ambulance services are consistently available for all New Zealanders in urban and rural communities – Budget 22.
Support the NZ Blood Service to meet the demand for organ donation and transplantation support – Budget 22.

3.6

Outbreak response and managing COVID-19

The National Public Health Service will work with the Ministry of Health, the Public Health Agency and Te Aka Whai Ora to continue to strengthen our national COVID-19 response to ensure that the:

- **Response to COVID-19 can continue and evolve in a seamless fashion within the health entities.**
- **Legacy built through the COVID-19 systems are carried through to the new health entities to ensure the system remains prepared and resilient to future threats.**

Equity is a critical cornerstone of our approach to COVID-19. We will continue to develop and implement targeted protections alongside and for those most vulnerable. Our management approach will adjust as required to mitigate the cumulative impacts of COVID-19 and other viruses.

The management of COVID-19 will shift to monitor variants of concern and integrate our response activity into the wider pandemic planning and public health processes. The COVID-19 response will be balanced with other disease mitigation priorities, along with other seasonal illnesses and communicable diseases. To progress this new approach, the National Public Health Service will work in close cooperation with the Ministry of Health's Public Health Agency and Te Aka Whai Ora to deliver a resilient long-term strategy to manage communicable disease outbreaks such as influenza, respiratory syncytial virus (RSV), whooping cough and measles.

COVID-19 vaccination continues to be one of the most effective public health measures to minimise poor health outcomes for people at most risk. Over the coming two years, the National Immunisation Programme will continue to monitor the status of the COVID-19 vaccine uptake, the use of boosters and the effectiveness of vaccines against new variants of concern.

The National Immunisation Programme will work with public health units, Māori and Pacific health providers, and disability sector leads to develop COVID-19 immunisation initiatives that suit the needs of local communities. The National Immunisation Programme includes vaccination programmes for childhood illness, measles, mumps and rubella (MMR) and flu, as well as COVID-19.

Finally, there are workforce gaps to address. Our workforce has been continuously involved in the COVID-19 response and this demand will continue for our public health workforce. The National Public Health Service will begin with supporting and growing existing staff, while also developing a national curriculum and training to meet the growth in need for public health expertise.

3.7

Strengthening our system enablers

3.7.1 Digital healthcare

Digital tools will make an important contribution to improve efficiency, outcomes and equity of outcomes in health services. Te Whatu Ora will grow the opportunities for people to use digital tools to access and use their health information, make appointments, receive phone and video consultations and use equipment to monitor their health at home. It will be aware of digital inclusion and ensure digital capabilities and non-digital pathways where required for equity. In addition to personal computers and smart phones, digital tools include patient portals and digitally enabled clinical equipment to remotely monitor health status. Digitally enabled equipment can range from personal monitoring devices for self-care to more integrated systems where patient data can be reviewed periodically or in real time by health practitioners. Access to health information, self and remote monitoring empowers people, whānau and communities to better manage their own health and wellbeing.

Equally important is the need for digital tools to provide greater support to our workforce. Well designed information systems can reduce the administration burden for our staff, making the right information available at the right time and place, and capturing information updates easily. There are significant opportunities to improve efficiency and effectiveness in our clinical workflow support to help staff engage with patients, and also in our non-clinical workflows that are crucial to enabling our services. Effective digital solutions will enable our clinical staff to spend more of their time with patients, more easily engage in multi-disciplinary working, share information with peers and engage in a range of education and information resources. They will also support our non-clinical staff to spend more time on high-value tasks, minimising repetitive searches for and entry of data.

Integrating digital technologies into our health service delivery system is an essential part of the shift to a single health system – interoperable digital systems and standardised data will enable information to be accessed and shared seamlessly. The health reforms provide the opportunity for Te Whatu Ora to take a national view of our digital challenges, use our scale to leverage better digital services, and build on successes from around the country. To do this successfully, we will invest in the infrastructure needed to support the automation of healthcare, bringing systems and services online to keep pace with demand and the public's expectations. More investment will provide more digital options in health, which will improve efficiency, resolve operational and security risks, and ultimately mean improved individual and whānau experiences of care.

DIGITAL HEALTHCARE ACTIONS
Create and implement actions to deliver national consistency in data and digital capability and solutions across Te Whatu Ora including streamlining duplicate legacy systems inherited from DHBs and Shared Service Agencies, to improve intra-operability and reduce operating costs.
Implement Hira, a user friendly, integrated national electronic health record, to the agreed level, ensuring the expected benefits of the investment are achieved, and taking all practicable measures to ensure that project milestones are met.
Scale and adapt population health digital services developed to support the COVID-19 response to serve other key population health priorities.
Improve the interoperability of data and digital systems across the hospital network, and between primary, community and secondary care settings.
Improve digital access to primary care as an option to improve access and choice, including virtual after-hours and telehealth, with a focus on rural communities.

3.7.2 Health infrastructure

Safe and fit for purpose facilities, sites and equipment are important parts of our health system. Te Whatu Ora is responsible for 1,200 buildings over 30 campuses, ranging from hospitals to smaller healthcare facilities. Evidence-based decisions are needed to determine when we strengthen hospital buildings and site infrastructure, and when it is better to enable more service delivery in primary care, community and home settings.

Health services need specialised facilities in their design and their fit-out, which includes clinical and digital equipment. These facilities are among the most challenging to plan, design and build. Getting our health infrastructure right is crucial to enable our workforce to deliver care safely and effectively, and for people to receive high-quality care.

To support Government decision-making on capital investment in the long term, a 10-15 year national asset management and investment plan is required to understand our capital. This includes completion of the National Asset Management Plan.

Asset management plans will be informed by national and regional service planning to identify population and service requirements. Included are all facilities and assets that enable care whether owned or rented, across all locations from hospital campuses to day surgery, community care and mobile services hubs.

Efficiencies will come from national standardisation and oversight of asset management, facilities design and delivery of construction. Te Whatu Ora will actively participate in the development and use of the Australasian Health Facilities Guidelines, along with development of Aotearoa specific guidance that includes ensuring facilities are fit for purpose for our diverse communities, including the needs of Māori.

As the national asset management and capital investment plans evolve, more investments will be identified as routine upgrades and business cases will focus on new, more complex projects. This will see facilities and equipment repaired and maintained faster and more efficiently in response to local requirements.

HEALTH INFRASTRUCTURE ACTIONS
Deliver the approved capital projects that are underway, taking all practicable measures to ensure that project milestones are met and anticipated benefits realised.
Deliver a National Asset Management Strategy and Capital Investment Plan by December 2023 including the information solution strategy, requirements and road map for asset management and investment analysis.
Develop design standards for Aotearoa health facilities, contributing to and building on the Australasian Health Facility Guidelines.
Develop partnerships with other government sectors to align with and leverage off large capital delivery programmes in other sectors.
Establish accessibility standards with the disabled community for all new builds, new contracts and new services including transport and mobility options, and develop a plan to make existing infrastructure, services and environments compliant with new standards.

3.7.3 Procurement and Supply Chain function

Te Whatu Ora will build an integrated, equitable, clinically enabled and sustainable procurement and supply chain system. Our procurement and supply chain teams will be brought together into a single function. Te Whatu Ora will leverage its scale to negotiate improved terms for delivery of products and services it relies upon, securing savings for Te Whatu Ora and streamlining the cost of doing business for our suppliers.

The Procurement and Supply Chain function will build on work already underway to implement a national digital product catalogue using global product standards and being interoperable with the Australian national product catalogue. Over time, this catalogue, together with national contracts, will deliver greater cost and demand transparency and support the development of health technology assessment. As systems mature, this will drive improvements in patient safety and ensure products subject to a manufacturer or regulator's recall notice are promptly located and removed from inventories.

The Procurement and Supply Chain function will develop a nationwide inventory management, warehousing and logistics strategy. Over time this will lead to efficiencies through optimisation of the types and numbers of products in inventory holdings and through reduced wastage of under used or expired products. Ultimately, effective inventory intelligence will underpin the systems that ensure the right products are ordered and deployed at the right time for each patient's care requirements.

PROCUREMENT AND SUPPLY CHAIN ACTIONS
Build the national procurement and supply chain function that implements supply chain strategy, policies, and guidance.
Establish the clinical engagement, sustainability, and equity requirements for the Procurement and Supply Chain function.

3.7.4 **Action on climate change**

Implement a climate sustainability and response plan across the health sector:

Implement emissions targets and performance indicators for national, regional and local levels, and build a national database to track the operational and embedded carbon emission impacts of the health sector.

With Iwi Māori and other stakeholders, co-design a framework for Te Whatu Ora's approach to climate change, service resilience and environmental sustainability.

Identify actions to achieve a 25 percent reduction of category-1 emissions by 2025, including a fleet optimisation plan, transitioning boilers to low emission technologies, a nitrous oxide scavenging and destruction pilot and supporting desflurane phase out.

Identify actions to achieve 25 percent reduction of category-2 emissions by 2025, including Te Whatu Ora designing an energy efficiency programme by 2023 and an LED lighting conversion programme.

Develop nationally consistent best practice for waste management and business travel policies to reduce flight-related emissions.

For all Te Whatu Ora procurement contracts, develop, include and enforce policies for social and environmental outcomes and sustainability principles

CLIMATE CHANGE ACTIONS
Implement a climate sustainability and response plan across the health sector.
Implement emissions targets and performance indicators for national, regional and local levels, and build a national database to track the operational and embedded carbon emission impacts of the health sector.
With Iwi Māori and other stakeholders, co-design a framework for Te Whatu Ora's approach to climate change, service resilience and environmental sustainability.
Identify actions to achieve a 25 percent reduction of category-1 emissions by 2025, including a fleet optimisation plan, transitioning boilers to low emission technologies, a nitrous oxide scavenging and destruction pilot and supporting desflurane phase out.
Identify actions to achieve 25 percent reduction of category-2 emissions by 2025, including Te Whatu Ora designing an energy efficiency programme by 2023 and an LED lighting conversion programme.
Develop nationally consistent best practice for waste management and business travel policies to reduce flight-related emissions.
For all Te Whatu Ora procurement contracts, develop, include and enforce policies for social and environmental outcomes and sustainability principles.

Section 4:

Priority populations | Ngā taupori matua

In this section we consolidate the actions related to our priority populations that are embedded across Te Pae Tata. This is to enable these to be seen collectively.

4.1

Māori health improvement

Meeting the requirements for a Māori Health Improvement Plan

This section of Te Pae Tata covers the priority actions that Te Whatu Ora will take to 2024 to recognise Te Tiriti and to improve Māori health outcomes. We have selected a few priority actions that Te Whatu Ora can take direct ownership of and which Te Aka Whai Ora will hold us to account for delivering. It is important to note that this Te Pae Tata contains a great many other actions which will have a direct impact on Māori health and equity.

The work that Te Whatu Ora does to improve Māori health reflects the expectation that Māori health improvement and equity is everyone's business. Te Aka Whai Ora ensures that our system has a strong focus on Te Ao Māori and that the responsibility for improving Māori outcomes is shared across the whole health system.

While the health system has failed Māori in nearly every domain of health and change is critically necessary, there is much we can do to accelerate the journey over the next two years.

Māori communities demonstrated through the COVID-19 pandemic that, when given the opportunity and resources to develop their own solutions, they can mobilise quickly, reach deep into their communities and achieve results that matter.

There are a growing number of services and solutions, including pockets of excellence that are making a difference. These services are delivered by both Māori and non-Māori providers and workforces. They demonstrate a genuine commitment to implementing Te Tiriti and to providing services that are culturally safe and acceptable. We can build on these successes by enhancing and scaling up those services that work for whānau and deliver results.

To set a course for action over the next two years and beyond, a number of key priorities have been selected that will direct where Te Whatu Ora will focus its efforts:

- Embed a Tiriti-dynamic health system.
- Eliminate inequities in health outcomes for Māori.
- Deliver on the aspiration of pae ora.

The health needs assessment for Māori, including the main causes of avoidable death and illness for Māori, influenced the selection of four of the six health priorities selected for action. These areas offer the greatest potential for positive intervention and results.

Mate pukupuku | People with cancer: Cancer is a leading cause of illness and death for Māori, making up 25 percent of preventable deaths for Māori women and 10 percent for Māori men. There are persistent inequities in cancer incidence, mortality and survival rates for Māori with those diagnosed being more likely to be diagnosed at a later stage, more likely to die and die sooner, than non-Māori with cancer.

Māuiuitanga taumaha | People living with chronic conditions: Chronic conditions, including diabetes, cardiovascular disease, chronic respiratory disease and stroke, make up the largest causes of death and impairment for Māori, with people often experiencing multiple conditions. Māori are more likely to be exposed to the leading and preventable risk factors of tobacco, obesogenic environments, unhealthy diets and alcohol. Risk factors are, in turn, strongly influenced by determinants such as poverty, social exclusion and racism.

Kahu taurima | Maternity and early years: The 2,000 days between pre-conception and a child's fifth birthday are critical to secure their future health and wellbeing. A healthy pregnancy, safe birth, good nutrition, low stress and nurturing whānau relationships will have a profound impact on giving a child a great start to life. While infant and maternal mortality are higher for Māori than non-Māori, many of the leading causes of deaths in Māori children, including prematurity, sudden unexpected death in infancy (SUDI), respiratory disease, or accident, injury and assault are preventable. Services have not been appropriate, effective nor sufficiently accessible to many Māori whānau and parents. Nearly half of Māori women do not have a Lead Maternity Carer in their first trimester of pregnancy and more than half of Māori children have not received their vaccinations by 18 months of age.

Oranga hinengaro | People living with mental distress, illness and addictions: The top ten contributors to overall health loss for Māori include mental health conditions like anxiety and depression, traumatic brain injury, alcohol use disorders and schizophrenia. Suicide is the second leading cause of death for Māori men and a major contributor to the life expectancy gap for both Māori men and women. Māori experience poorer mental healthcare – being less likely to receive pharmaceutical treatment and more likely to be placed in seclusion and under compulsory treatment orders. Poor mental health results from many of the same drivers of health inequities – racism, colonisation, intergenerational trauma, poverty and cultural disconnection. A significantly higher proportion of Māori than non-Māori experience stress and difficulty in daily life, and experience social isolation and exclusion.

All the above areas need a strong population health approach. The creation of the priority for Pae Ora | Greater Health and Wellbeing is derived from the need to create environments in our communities that support healthy lifestyles for whānau.

Each of the conditions above relies on a core set of activities to enable change:

Māori leadership and mana motuhake: The autonomy of Māori within the health sector to lead as Māori will be strengthened to support a system that is characterised by a genuine Te Tiriti partnership. Iwi Māori Partnership Boards are an important part of this shift towards an equity and Tiriti-dynamic system. The future will be characterised by Māori in leadership positions making decisions in their own right and in partnership with other key stakeholders. The system will engage in a mana-enhancing way with the Māori health workforce, and Māori technical experts will be included at all levels of health system design and delivery.

Evidence-based policies for prevention and wellbeing: Strong population health and prevention is critical to achieve equity and overall health improvement. This includes action on the social, cultural and commercial determinants of health that have the strongest influence on Māori health inequities. The future will be characterised by a system that prioritises prevention and early intervention. It aims to reduce risk and build on the positive factors that contribute to Hauora, for example, whānau wellbeing, removing discrimination against Tāngata whaikaha | Disabled people, and promoting the uptake of healthy food options.

Integrated, whānau-centred services: Services will be whānau-centred and cohesive. This requires a greater focus on understanding the health needs of communities; addressing these needs in a more connected way; expanding outreach and home-based care; and addressing the social, cultural and commercial determinants of health. Health services must provide a safe, culturally aligned, diverse and inclusive space. Services must offer comprehensive wellbeing screening and support, where 'any door is the right door', backed up with community engagement, well developed primary, secondary and tertiary pathways, system-level solutions and Māori leadership.

Primary care designed to work for Māori: Primary care services for the future will be accessible, affordable, available and appropriate for Māori. Increased access to primary care ensures high-quality care is available where it is most needed and where there are considerable benefits to be gained, avoiding the need for hospital treatment. This will make positive changes in all leading health areas for Māori, including cancer, chronic conditions, mental health, maternity care and support for pēpi in their earliest years. Radically redesigning the primary care system will be done with Māori autonomy, leadership and oversight. Iwi Māori Partnership Boards and locality planning will be critical here.

A culturally safe workforce, with many more Māori workers and leaders: Māori working in the health and disability sector make the biggest contribution to improved health outcomes and equity for Māori. We will grow the number of Māori coming into health careers while also making our organisations safe and mana-enhancing places, not just to work in, but places to develop careers and exert influence. The workplace will value, support and protect Māori from discrimination and racism, and will do this through a universal expectation of cultural safety. Cultural safety training will help make a tangata tiriti workforce of healthcare professionals who are conscientised around racism and bias. Everyone will bring this awareness into their service to guarantee quality of care.

Below, we outline the priority actions across Te Pae Tata that ensure equity for all Māori and make Māori health outcomes everyone's accountability. These actions shift the system towards Māori outcomes by growing Māori leadership through mechanisms such as Iwi Māori Partnership Boards, increasing Māori in leadership positions and in the general workforce, strengthening Māori providers and improving access to Te Ao Māori services.

We will strengthen the intelligence regarding how well the system performs for all Māori, including specifically where and how we are demonstrating a successful reduction in inequities.

Māori Health Gain areas

MĀORI HEALTH IMPROVEMENT ACTIONS
Partner with Iwi Māori Partnership Boards to develop interventions that are tailored for Māori, build community capability and ultimately work for Māori.
Work with the Public Health Agency to develop and implement evidence-based public health and legislative interventions that reduce harm from alcohol and other drugs.
Review the national approach to Māori suicide prevention and construct suicide prevention approaches consistent with mātauranga Māori to reduce the rate of suicide and suicidal behaviour.
IMPROVE MATE PUKUPUKU FOR MĀORI
Take a pro-equity approach to age thresholds for access to screening and removing barriers to primary care to improve early detection.
Ensure access to timely best-practice treatment once cancer is diagnosed, with auditing to ensure deviations are justified.
Continue to explore programmes for lung cancer early detection and improve funding of pharmacological treatments.
IMPROVE MĀUIUITANGA TAUMAHA FOR MĀORI
Redesign primary care to remove barriers to access for Māori and to provide a more comprehensive option for whānau.
IMPROVE KAHU TAURIMA FOR MĀORI
Provide wrap-around support for wāhine hapū antenatal and birthing care, including identifying ways to provide longer-term intervention and prevention services.
Design immunisation and Well Child Tamariki Ora services that work for Māori and build off a strongly integrated maternity service.
Develop whānau-orientated interventions that provide intensive support for maternity and the early years.

IMPROVE ORANGA HINENGARO FOR MĀORI
Design and expand Te Ao Māori mental health service solutions including primary mental health and wellbeing services, known as Access and Choice.
Develop local urban and rural community networks, including NZ Police, to support people who are in mental distress or experiencing an acute mental health and addiction episode.
Increase the availability of, and trial, new models of taurite specialist Māori mental health and addiction services.

Enablers for Māori Health Gain

STRENGTHEN AND GROW IWI MĀORI LEADERSHIP
Iwi Māori Partnership Boards are in place and engaged locally, regionally and nationally.
More Māori are in leadership and decision-making roles in Te Whatu Ora and Te Aka Whai Ora.
GROW IWI MĀORI RESEARCH AND EVIDENCE, INCLUDING MĀTAURANGA MĀORI
Establish a Te Ao Māori intelligence and insights function, that includes use of mātauranga Māori.
IMPLEMENT EVIDENCE-BASED POLICIES FOR PREVENTION
Implement evidence-based policy interventions to address health priorities for Māori, including tobacco control, alcohol, obesity and diet.
DEVELOP PRIMARY AND COMMUNITY CARE THAT WORKS FOR MĀORI
Fairly fund Māori providers, valuing their role in primary care and maximising the value of comprehensive models of service delivery. Where there is good performance, we will develop longer-term and more flexible contracts to improve outcomes.
Commission comprehensive primary and community care services for Māori populations that improve access.
Commission a wider range and greater volume of Te Ao Māori health services.

CREATE A CULTURALLY SAFE WORKFORCE, INCLUDING A STRENGTHENED MĀORI WORKFORCE
Support educational interventions to increase Māori access to health professional training within the tertiary sector.
Support health sector interventions to increase the number and type of Māori health workers within the current workforce.
Set mandatory education for Te Tiriti o Waitangi, equity, racism and bias for the whole health workforce to ensure they can deliver culturally safe and culturally competent healthcare.
Assess and improve the cultural safety of healthcare organisations.
Build a network of non-Māori practitioners who are mentors and leaders on cultural safety work, who can build Te Tiriti awareness and help non-Māori understand their responsibilities to Māori.
ENSURE ACCOUNTABILITY FOR RESULTS FOR MĀORI
Ensure universal responsibility for monitoring performance by ethnicity and acting on the results.
Set Māori equity key performance indicators within health service delivery and seek action plans for remediation where performance is below the indicator, where there is no existing plan.
Embed Māori sovereignty frameworks and practice for governance of data and information, privacy and security. Ensure appropriate data and protection standards are in place.
Ensure ethnicity data is collected according to a common ethnicity data protocol and there is a universal responsibility for all parts of the system to monitor performance on equity, with public transparency of performance.
Empower the system to identify and implement solutions to address inequities and monitor the impact of actions.
Ensure we meet the Ministry of Business, Innovation and Employment (MBIE) target that at least 5 percent of contracts are awarded to Māori.

4.2

Pacific health

The health and disability system reform is an important opportunity to ensure equity in our health system. We know that many areas of the health system are not working well for Pacific people, whānau, aiga, ngutuare tangata, kainga, famili, kāiga, magafaoa, vuvale and kaaiga (families) and communities. We have known about these problems for a long time. The persistent five-to-six-year gap in life expectancy between Pacific and non-Māori and non-Pacific people, has been demonstrated for at least 20 years.

Some parts of our system have responded. Our Pacific health providers have worked closely with communities to design services that reflect Pacific families and their lives. We have invested in more community owned and led health responses and have begun to engage with communities more meaningfully.

Over the next two years, we will embark on an exciting programme of work that will build and strengthen the foundations for Pacific health in the reformed system, while starting on a long-term path to address key Pacific health priorities. These enablers and priorities were determined using the lessons we have learned from the COVID-19 pandemic, from what Pacific communities and the health sector have told us and following an in-depth health needs assessment.

Ola Manuia | Interim Pacific Health Plan provides more detail on Te Whatu Ora's approach to strengthening Pacific Health enablers and taking action on Pacific Health priorities.

The actions we take over the next two years will support Pacific families and communities to stay well and enable Pacific people to access the care they need more easily, where and when they need it.

To get there, we must continue the path forged by the COVID-19 pandemic: working together, investing together, learning together and achieving wellbeing together. We will take a dual approach that involves:

STRENGTHENING SIX KEY ENABLERS TO BUILD CRITICAL PACIFIC HEALTH FOUNDATIONS AND INFRASTRUCTURE, INCLUDING:	USING THE ENABLERS TO ACCELERATE GAINS IN SEVEN PRIORITY AREAS OF PACIFIC HEALTH, INCLUDING:
• Population health approaches and intersectoral collaboration to act on the socioeconomic and wider determinants of health. • Strong embedded mechanisms for Pacific families, community and lived experience voice. • Support and development of the Pacific health workforce. • Pacific provider support and development. • A dedicated Pacific commissioning function. • A robust Pacific health data and intelligence function.	• Mothers and babies. • Children and youth. • Older people. • Tagata sa'ilimalo | Disabled people. • Long-term conditions, including cancer, diabetes and gout. • Mental health and wellbeing. • Pandemic response, including addressing gaps and missed care over the last two years.

We have started to make gains for Pacific people through the efforts of communities and health workers across the country, and there are many excellent models across the country.

Ola Manuia sets out the details of how we will build on those successes and make an even stronger contribution to a thriving, resilient and prosperous Pacific Aotearoa.

PACIFIC HEALTH ACTIONS
Embed diverse Pacific voices in decision making across the health system.
Build on the Pacific community engagement framework in partnership with Pacific communities and relevant stakeholders to embed Pacific aiga and community voice into the reformed system.
Strengthen and build on existing Pacific networks, and develop new networks where there are current gaps, that include churches and other community groups, to develop, support and implement the engagement framework.
Support Pacific communities and providers to be active partners in the establishment of localities.

Establish a robust national Pacific health data and intelligence function.

Establish a highly-connected national Pacific Clinical Network to help support and mobilise the clinical workforce and create a forum where insights from front-line staff are systematically captured and used to inform quality improvement and service development.

Commission research to support development of evidence-based care pathways and responsive models in priority clinical areas, including maternity and early years care, long-term conditions and mental health services.

SUPPORT STRONG PACIFIC COMMISSIONING AND PACIFIC PROVIDER DEVELOPMENT

Resource regional Pacific Community Hubs so that Pacific providers can work together in an integrated way at local and regional levels.

Co-create partnerships with new Pacific providers in growth localities that do not currently have a Pacific health provider.

Conduct feasibility studies for Hawke's Bay and South Island providers to expand into primary care.

Support the continuation of innovative models of care developed through the COVID-19 response:

- *Strengthen Pacific providers by investing in the infrastructure required to sustain innovative models of care.*
- Assess how innovative models of care can be scaled up at different regional levels.

Fund Pacific providers who implement models of Pacific family-centred care that integrate maternity, early years care, primary care, hospital and social service providers.

Enter into high-trust, flexible and outcomes-based contracts with Pacific providers based on a shared understanding of their needs and innovative approaches.

ADVANCE PACIFIC HEALTH PRIORITY AREAS

Develop a Pacific whānau-focused diabetes integrated care model:

- *Invest in a South Auckland-based pilot over a four-year period that brings together Pacific communities and providers to deliver health promotion, community-based primary and secondary care focused on prevention, early intervention and optimal treatment of diabetes.*

Evaluate current Pacific whānau-focused diabetes integrated care models, with a continuum of care from primary to high-quality specialist care, including screening, prevention, early treatment and management of eye, foot and kidney complications;

- and assess how these can be scaled up at different localities and regional levels.

Support Pacific providers to identify and address the health needs of priority communities, including youth, the rainbow community, older people, Tagata sa'ilimalo/the collective of families, carers and people with disabilities, and those with lived experience of mental illness and addiction.
Ensure Pacific people and aiga are prioritised in the restart of planned care following the pandemic.
Develop and implement Pacific integrated models of care for Kahu Taurima | Maternity and early years.
Work with health providers and sector leaders to address the health gaps and needs of Pacific children following the pandemic, with a focus on strengthening immunisation services and oral health with improved coverage.
Support ongoing work across the sector to reduce current cancer health inequities of Pacific people and families: • *Urgently address the decline in Pacific people's breast, bowel and cervical cancer screening rates and ensure Pacific people with a diagnosis get the care needed.* • Work with relevant Northern region health providers and health leaders to provide sufficient resource and ongoing support for a consistent approach to the early diagnosis and treatment of endometrial cancer. • Work with Te Aho o Te Kahu to develop closer to home care principles for cancer patients and their aiga.
Work with Northern region health providers, health leaders and researchers to develop maternal mental health models of care for Pacific women; to be implemented as part of Kahu Taurima.
SUPPORT AND GROW A STRONG PACIFIC WORKFORCE
Develop a comprehensive Pacific Health Workforce Development Strategy to attract, train, strengthen, upskill and retain a growing Pacific workforce.
Work with the education sector to identify secondary and tertiary education barriers to Pacific health education and training, and the solutions to help.
Invest in initiatives and activities supporting Pacific health providers' workforce capability and capacity development.
Establish a programme to support the training and employment of Pacific nurse specialists in priority clinical areas of maternity and early years care and diabetes.
Investigate options to increase General Practice Education Programmes 1 and 2 teaching practices within Pacific providers.

4.3

Health of Tāngata whaikaha | Disabled people

Creating a fully accessible, inclusive and equitable health system for Tāngata whaikaha | Disabled people means better healthcare for everyone as many people also experience temporary disabilities due to illness, injury and age. Tāngata whaikaha | Disabled people make up nearly a quarter of New Zealanders. They belong to all age, ethnic and cultural groups, gender identities, sexualities, localities, socio-economic groups and every whānau and community. The health system reform has provided the opportunity to reimagine a public sector that collaborates with disabled New Zealanders in a mana-enhancing way to achieve equal health outcomes and live good lives.

The health system in Aotearoa does not work for Tāngata whaikaha | Disabled people. Tāngata whaikaha | Disabled people in Aotearoa experience a wide range of inequities when accessing health services and poorer health outcomes compared to non-disabled people. Without any historic efforts to collect disability data, the voices, experiences and health outcomes of Tāngata whaikaha | Disabled people are not reflected in health system priorities, policies, or accountabilities. Inequities in access to healthcare are particularly intensified for Māori disabled people, Pacific people with disabilities and disabled people who experience other forms of intersectional marginalisation.

Te Whatu Ora in partnership with Te Aka Whai Ora, will work with Whaikaha the Ministry of Disabled people and are committed to prioritising Tāngata whaikaha | Disabled people as an equity group. This commitment is a historic moment and represents a formal recognition that the health system must take responsibility for providing appropriate, accessible healthcare for Tāngata whaikaha | Disabled people. Transforming the health system approach to support disability will be complex; it requires us to challenge the basic assumptions, entrenched ableism and outdated models that the system is built on.

The disability community is calling for a rights-based, equity driven approach to health that sees, welcomes, celebrates, listens to and treats Tāngata whaikaha | Disabled people well and on an equal basis with non-disabled people. The Aotearoa disability community see a truly equitable healthcare system as one in which Tāngata whaikaha | Disabled people are treated with dignity and fairness, included, visible, and 'belong' in the healthcare system on an equal basis with their non-disabled peers.

Three key principles will underpin the work of Te Whatu Ora to reframe how we see, value and work with Tāngata whaikaha | Disabled people:

PRINCIPLE	EXPLANATION	OBLIGATIONS
Human rights model of disability	The transformed health system recognises and understands disability using the human rights model to inform its approach to service design, planning and delivery.	• United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). • Te Tiriti o Waitangi.
PRINCIPLE	**EXPLANATION**	**KEY ENABLERS**
Nothing about us without us	Tāngata whaikaha	Disabled people must lead the conversation about what an equitable health system means to them at every step of the way.	• Enabling Good Lives principles.
Connected, holistic models of care	Tāngata whaikaha	Disabled people are treated as whole people with access to consistent, connected, high-quality, culturally and age-appropriate care throughout the health system.	• Digital, data and intelligence. • Localities model. • Partnership with Te Aka Whai Ora and Pacific team in Te Whatu Ora.

These principles provide the foundations for an inclusive, accessible and equitable health system for Tāngata whaikaha | Disabled people. Based on this foundation, the priority areas and action points outlined below have been selected. These priorities are both aspirational and immediate, with a clear action plan to guide our work now to build a transformed health system that works with and for Tāngata whaikaha | Disabled people.

Key priorities in the next two years include:

Make all health services accessible, inclusive and equitable for Tāngata whaikaha | Disabled people: 'Accessibility' in the context of disability refers to a specific set of requirements and accommodations that ensure Tāngata whaikaha | Disabled people have equitable access to the environment, information and communications. Inclusive health services are accessible according to these requirements, and actively welcome and value Tāngata whaikaha | Disabled people for who they are rather than defining them by their clinical requirements or diagnosis.

Create twin-track pathways and services for Tāngata whaikaha | Disabled people and communities who need them: Tāngata whaikaha | Disabled people have the same healthcare requirements throughout their lives as non-disabled people, as well as some specific healthcare requirements related to their disability. To ensure equity, Te Whatu Ora will commit to making sure all health services are accessible and inclusive to Tāngata whaikaha | Disabled people, while also recognising and responding to specific services or pathways the disability community needs.

Commit to continued radical and measurable transformation toward person, whānau and community driven, holistic, inclusive and accessible healthcare services: Making healthcare services accessible, inclusive and equitable is the first step toward radical transformation. Long-term system change requires actions that fundamentally change how the health system understands, interacts with and includes Tāngata whaikaha | Disabled people.

The following actions create a new baseline for how Tāngata whaikaha | Disabled people feel engaged in the health system. It redefines the minimum expectation that new health services and infrastructure are accessible, patient-related information published by Te Whatu Ora and Te Aka Whai Ora is accessible, and that Tāngata whaikaha | Disabled people, their health needs and health inequities are understood. Also, when health services are designed and planned, Tāngata whaikaha | Disabled people are included to create intelligence regarding their experience in the health system.

HEALTH OF TĀNGATA WHAIKAHA | DISABLED PEOPLE ACTIONS
Establish accessibility standards for all new builds, new contracts and new services including transport and mobility options, and develop a plan to bring existing infrastructure, services and environments to be compliant with new standards.
Establish baseline accessibility and usability requirements for the production and publication of all public facing health information, including accessible language, accessible channels to find and use information, and alternative formats for health information.
DEVELOP INCLUSIVE MODELS OF CARE
Train the healthcare workforce on supported decision-making and informed consent processes and implement inclusive practices in models of care, for example, NZ Sign Language interpreters, hoists and sensory reduction, using e-technology.
Develop a plan to ensure health careers are accessible, equitable and inclusive for Tāngata whaikaha | Disabled people.
PRIORITISE DISABILITY IN SERVICE PLANNING AND COMMISSIONING
Mandate pro-equity strategic development, service planning and commissioning embedded with social determinants of health and wellbeing outcomes for Tāngata whaikaha | Disabled people.
Establish a Tāngata whaikaha | Disabled people strategic leadership team to oversee implementation of Te Pae Tata and maintain strong, transparent, continuous community involvement.
SUPPORT TĀNGATA WHAIKAHA | DISABLED PEOPLE TO LEAD THE CONVERSATION
Increase the disability leadership capacity in the design and development of health services.
Implement appropriate and accessible feedback processes for locality, service design and commissioning processes.
Support Tāngata whaikaha | Disabled people in culturally-appropriate ways in Māori, Pacific and other community-specific health services ensuring they are led by Tāngata whaikaha | Disabled people from those communities.
Implement the Patient Profile and National Health Index to provide a foundational data ecosystem to understand inequities facing Tāngata whaikaha | Disabled people.

Section 5:

A focus on performance | He aronui ki te whakatinanatanga

Te Pae Tata lays out changes in how we ensure people and whānau are at the centre of our system, how we improve health outcomes and drive equity in priority areas, and how we manage and organise health service delivery systems to be as effective as possible.

Te Pae Tata responds to the interim Government Policy Statement on Health, the Budget Vote Health and Whakamaua | Māori Health Action Plan 2020-2025. These documents include performance measures designed to monitor the performance of the health service delivery system. Appendix two shows how the actions in Te Pae Tata are aligned to the five key shifts outlined by the Minister of Health, the interim Government Policy Statement on Health and the Pae Ora (Healthy Futures) Act 2022.

5.1

Performance reporting

Demonstrating achievement against this interim plan is important for New Zealanders to see what benefits are being achieved through this reform and the benefits of this scale of change. Appendix three outlines all of the performance measures that are relevant to the sections of Te Pae Tata.

These are only the beginning. Building an approach that values the impact of health services for people and the outcomes that are achieved will be part of our performance approach from 2024.

In this first two years, performance reporting includes the following elements:

- Reporting on the performance measures agreed in the accountability documents for Te Whatu Ora and Te Aka Whai Ora.
- Achievement against the actions outlined in Te Pae Tata as milestone achievements, including the extent and coverage of the change.
- Achievement against the two year financial pathway and appropriations as outlined by Treasury.
- From 1 January 2023 we will provide health service access performance on monitoring unwanted variation in service access and outcome and equity measures for the four key priority areas.
- From 1 January 2023 we will provide outcome and equity measures in our four priority areas where we are driving whole of system improvement. These areas are Kahu Taurima | Maternity and the early years; Mate pukupuku | People with cancer; Māuiuitanga taumaha | People living with chronic health conditions such as diabetes, heart disease, respiratory conditions, stroke and gout; and Oranga hinengaro | People living with mental distress, illness and addictions.

Te Aka Whai Ora will monitor the delivery of hauora Māori services by Te Whatu Ora and provide public reports on the results of that monitoring.

After the first twelve months of operation, both entities will establish baseline knowledge as to how the system is performing to enable targets to be set.

Affordability

The Pae Ora legislation describes future New Zealand Health Plans (post 2024) as fully costed, which will be the first time the New Zealand health system has had future funding certainty for a three-year period. We will implement strong integrated planning processes, including a medium-term plan for managing cost pressures and building resilience. These will inform the development of the 2024-2027 Plan.

The first Plan – Te Pae Tata – is designed to balance the expectations of investment from Government as outlined in the interim Government Policy Statement on Health (iGPS) and Budget 22, within our financial constraints. The affordability of these changes is designed on a simple premise – that the total budget must not be exceeded and all health plan actions must have a clear funding source.

In Te Pae Tata all the actions have one of the following funding sources:

- Directly funded as an initiative in Budget 22.
- Funded by a previous Budget decision and the revenue has transferred to Te Whatu Ora from The Ministry of Health.
- Requires no additional funding as it is funded by the consolidation of existing resources.
- Funded by the re-commissioning (redesign and re-contracting) of existing services.

Financial performance will be reported as required by the iGPS, Health System Indicators and Vote Health. The monitoring of value for money and financial efficiency will be developed in the first twelve months of operation to inform the preparation for future health appropriations.

Appendices

Appendix One: Glossary of terms and acronyms

TERM	DEFINITION
Aiga	Family.
Hauora	Health.
HUD	Ministry of Housing and Urban Development
Kaimahi hauora	Health workers.
Kaiāwhina	Assistant, helper.
Kaimanaaki	Support worker(s) and community health worker(s).
Kaitiaki	Guardian, steward.
Kaupapa Māori	The knowledge, attitudes and values that are inherently Māori as held and followed by hapū and Iwi. This is synonymously linked to mātauranga Māori and underpinned by Te Tiriti o Waitangi, self-determination, cultural validity, culturally preferred teaching, socioeconomic mediation of Māori disadvantage, whānau connections, collective aspirations, and respectful relationships underpinned by equality and reciprocity.
Kaumātua	Māori elder.
Mana Motuhake	Self-determination, autonomy.
Mana Whenua	Customary authority exercised by an Iwi or hapū in an identified area.
Mātauranga Māori	Māori knowledge systems that reflect indigenous ways of thinking, relating, and discovering. It links indigenous peoples with their environments, is often inspired by environmental encounters and is conveyed within the distinctiveness of indigenous languages and cultural practices.
Pakeke	Adult.
Pēpi	Baby.
Rangatahi	Youth.
Tamariki	Children.
Tagata Sa'ilimalo	Collective concept inclusive of families, carers and people with disabilities.
Tangata Whenua	People of the land. In reference to a particular place, it means the Iwi or hapū that has mana whenua over the area.
Taonga	Treasure.
Taurite services	These are services that braid clinical and cultural care. They can be delivered by a Māori provider or a non-Māori provider. If delivered by a non-Māori provider, high-quality taurite services are delivered in partnerships with Māori.
Te Aho o Te Kahu	Cancer Control Agency.
Te Ao Māori	Māori world view.
GDP	Gross domestic product.
HIRA	National digital exchange platform for health information.
KPI	Key Performance Indicator.
LINAC	A medical linear accelerator directs beams of radiation into tumours to treat people with cancer.
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities.
Whānau	Family.

Appendix Two: Reconciliation of Te Pae Tata | interim New Zealand Health Plan against Government expectations

This Appendix provides an overview of the Government's expectations for Te Pae Tata | interim New Zealand Health Plan as outlined in the cabinet paper 'Health and Disability System Review: Proposals for Reform', the Pae Ora (Healthy Futures) Act 2022 and the interim Government Policy Statement on Health (iGPS). It provides an assessment of how Te Pae Tata meets these requirements.

REQUIREMENT	HOW TE PAE TATA DELIVERS THE REQUIREMENT	REFERENCE
FIVE KEY SHIFTS FROM THE CABINET PAPER 'PROPOSALS FOR REFORM'		
1. The health system will reinforce Te Tiriti principles and obligations	Te Pae Tata has a strong focus on building a health system which holds Te Tiriti o Waitangi as its foundation – placing Te Tiriti at the forefront of thinking and providing opportunities to enact Te Tiriti principles and articles to improve health outcomes for Māori. This includes: • Embedding Te Tiriti and making this a collective responsibility. • Balancing leadership between the Crown and Māori communities. • Māori exercise decision-making authority over matters of importance to them. • Considering Te Ao Māori | the Māori world views, including mātauranga Māori and kaupapa services to take bold action to address discrimination, bias, and systemic racism throughout the system. • Te Aka Whai Ora facilitating and resourcing Iwi and Māori development along with Iwi Māori Partnership Boards, will be equipped to exercise self-determination at all levels of the system. • Te Whatu Ora and Te Aka Whai Ora enabling and supporting the voice of whānau in the design and delivery of services that are culturally safe and produce equitable outcomes. • Jointly investing to grow the reach of kaupapa providers and Te Ao Māori solutions, and developing the health sector's understanding and application of Te Ao Māori approaches and models. • Enabling and supporting Māori through genuine and meaningful engagement in the design, delivery and monitoring of health services to reflect their needs and aspirations and improve hauora Māori outcomes. • Working in partnership with Māori to establish promotional and prevention measures to protect and improve Māori health and wellbeing. • A commitment to achieving equitable outcomes for Māori.	 See 'Building our foundations' and Section 4

REQUIREMENT	HOW TE PAE TATA DELIVERS THE REQUIREMENT	REFERENCE
2. All people will be able to access a comprehensive range of support in their local communities to help them stay well	Te Pae Tata reinforces the need for a more unified and joined-up approach to ensure all communities have access to a comprehensive range of support in their local community. This includes: • The establishment of localities, which is the key mechanism to ensure communities have access to a comprehensive range of supports in their local communities. Locally based service delivery will be supported through: – Locality partnerships – that include Iwi and Māori, trusted community leaders, health and social sector providers, and councils, who collaborate with communities, whānau and consumers to deliver locality plans. – Provider networks – local health providers will form networks and work together to deliver better care for whānau, regardless of where they seek it. • The strengthening of primary care, including the development of comprehensive primary and community care teams that will give people better access to a broader range of services in their communities. These comprehensive primary and community care teams will be commissioned according to the needs of the community and supported to deliver high-quality care for all people in all locations. • Improving the integration between primary and community care with secondary services will support the delivery of care closer to home and improve the experience people have with the health system. • The enhancement of digital health care and intelligence to improve the efficiency and effectiveness of care. This includes the establishment of a national after-hours primary healthcare telehealth service.	See Sections 2.1–2.3, 3, 4.1–4.3
3. Everyone will have access to high-quality emergency or specialist care when they need it	Te Pae Tata has identified accessible, high-quality emergency and specialist care as a focus for these first two years, with a particular aim to reduce the unwarranted variation in outcomes and access the system currently delivers. The establishment of regional hospital and specialist networks, supported by digital tools and health intelligence, and the development of national specialist pathways in priority areas for improved outcomes and equity gain, will ensure this shift is realised. This will make better use of the hospital and specialist capacity we have nationally, ensuring people are able to access the care they need. Te Pae Tata also focuses on the availability of responsive transport and accommodation options, working with emergency road and air ambulance services to ensure the capacity to respond to emergencies.	See Sections 3.3–3.5
4. Digital services will provide more New Zealanders with the care they need in their homes and local communities	Digital services are a critical part of our future models of care and underpin many of the transformations related to our service delivery system, in public health, primary and community care, rural healthcare, and hospital and specialist services. Te Pae Tata commits to: • Integrating digital technologies into our models of care and improving the digital infrastructure of the health system. This will enable people to access care in convenient ways and improve the uptake of innovations that deliver more efficient and effective care outcomes. • Supporting our workforce and healthcare providers by lifting digital capability across the system, so everyone has access to digital tools and has the capability to use them effectively. • Improving digital access to primary care as an option to improve access and choice.	See Section 3

REQUIREMENT	HOW TE PAE TATA DELIVERS THE REQUIREMENT	REFERENCE
5. Health and care workers will be valued and well-trained for the future health system	Te Pae Tata recognises the many pressures our health workforce whānau experience and commits to significant change to make a career in health a career of choice. This includes addressing workforce shortages, diversifying our workforce and investing in training and development. Te Pae Tata also recognises that developing an inclusive leadership and culture is critical to the effectiveness and sustainability of the health system. We commit to diversifying our leadership, embedding the lived values within Te Mauri o Rongo – The Health Charter in Te Whatu Ora and Te Aka Whai Ora, and proactively developing our future leaders in health.	See Sections 1.2-1.3
INTERIM GOVERNMENT POLICY STATEMENT ON HEALTH PRIORITIES		
Embedding Te Tiriti o Waitangi across the health system	Te Pae Tata has a strong focus on building a health system which holds Te Tiriti o Waitangi as its foundation – placing Te Tiriti at the forefront of thinking and providing opportunities to embed Te Tiriti across the system. This includes: • Balancing leadership between the Crown and Māori communities. • Māori exercise decision-making authority over matters of importance to them. • Considering Te Ao Māori world views of health, including mātauranga Māori, and take bold action to address discrimination, bias, and systemic racism throughout the system. • Te Aka Whai Ora facilitating and resourcing Iwi and Māori development, along with Iwi Māori Partnership Boards, will be equipped to exercise self-determination at all levels of the system. • Te Whatu Ora and Te Aka Whai Ora enabling and supporting the voice of whānau in the design and delivery of services that are culturally safe and produce equitable outcomes. • Jointly investing to grow the reach of kaupapa providers and Te Ao Māori solutions, and developing the health sector's understanding and application of Te Ao Māori approaches and models. • Enabling and supporting Māori through genuine and meaningful engagement in the design, delivery, and monitoring of health services to reflect their needs and aspirations and improve hauora Māori outcomes. • Working in partnership with Māori to establish promotional and prevention measures to protect and improve Māori health and wellbeing. • A commitment to achieving equitable outcomes for Māori.	See 'Building our foundations' and Section 4.1
Laying the foundations for the ongoing success of the health system	Te Pae Tata 'Building our foundations' outlines how embedding Te Tiriti, implementing a population health approach, driving for improved health outcomes, equity of access and sustainability are the foundations of the new health system we are building. Te Pae Tata aims to unify the health system, ensuring that all those who work in health operate with a 'one system' culture and ethos. Te Pae Tata recognises the criticality of health intelligence to our ability to continually improve the performance of our health system and ensure its ongoing success.	See 'Building our foundations' and Sections 1, 3, 4 and 5

REQUIREMENT	HOW TE PAE TATA DELIVERS THE REQUIREMENT	REFERENCE
Keeping people well in their communities	A key priority of Te Pae Tata is keeping people well in their communities. Key components of our drive to keep people well and ensure care is provided as close to home as possible includes: • The focus on pae ora – better health in communities, strengthening our prevention efforts and community wellbeing with the leadership of Iwi Māori Partnership Boards, hapū, community, local government, social sector and other partners. • The establishment of localities, which is the key mechanism to ensure communities have access to a comprehensive range of supports in their local communities. • The strengthening of primary care, including the development of comprehensive primary and community care teams that will give people better access to a broader range of services in their communities. These comprehensive primary and community care teams will be commissioned according to the needs of the community and supported to deliver high quality care for all people in all locations. • Improving the integration between primary and community care with secondary services will support the delivery of care closer to home and improve the experiences people have with the health system. • The establishment and strengthening of the critical partnerships providing wider healthcare support. • The integrated pathways of care, digital tools and health insights and intelligence across the whole system. • The enhancement of digital healthcare and intelligence to improve the efficiency and effectiveness of care. This includes the establishment of a national after-hours primary healthcare telehealth service.	 See Building our foundations; Sections 1.4, 2.1-2.5, 3, 4.1-4.3
Achieving equity in health outcomes	Te Pae Tata aims to improve health equity through all actions across all priority areas. Section 2 details our health gain priority areas which have been chosen specifically because they are the areas that deliver consistently inequitable outcomes for New Zealanders and are therefore the areas where we can make the greatest gains in health equity. With the investment in a strong and diverse workforce that reflects our communities and the development of models of care that address the needs of Māori, Pacific people and Tāngata whaikaha | Disabled people, we will be well equipped to improve health outcomes for people who are currently underserved by the health system. The strengthened use of health insights and intelligence is particularly important to improve health inequities. A key focus of Te Pae Tata is to improve the quality of health and equity intelligence, particularly for Māori, Pacific people, Tāngata whaikaha | Disabled people and rural communities. This includes improving our data collection, knowledge synthesis and responsive action through to monitoring and evaluation.	 See Building our foundations; Sections 1.2, 1.3, 1.4, 2, 3, 4.1-4.3

REQUIREMENT	HOW TE PAE TATA DELIVERS THE REQUIREMENT	REFERENCE
Developing the health workforce of the future	Te Pae Tata recognises the many pressures that our health workforce whānau experience and commits to significant change to make a career in health a career of choice. This includes addressing workforce shortages, diversifying our workforce, investing in training and development and actions to strengthen leadership and culture. Te Pae Tata also focuses on the importance of deliberate and dynamic workforce planning, which includes stronger utilisation of data and intelligence to fully understand workforce supply and demand, and working in partnership with education and training providers on pipeline strategies.	 See Section 1.2-1.4
Ensuring a financially sustainable health system	At the core of Te Pae Tata is the implementation of a population health approach which strengthens action in health promotion and prevention, and addresses the social determinants of health. By intervening earlier and working with our cross-agency partners to improve people's health and wellbeing, we can mitigate some of the future demand for healthcare, enhancing the sustainability of our health system. Te Pae Tata recognises the significant opportunity to improve efficiency in administrative and operating systems that will have a positive impact on financial performance; supported by the simplification of our system. Note that Te Pae Tata has been reconciled with Vote Health appropriations and Budget 22 funding to ensure all actions are deliverable within the funding available over the next two years.	 See 'Building our foundations' and Section 5
PAE ORA (HEALTHY FUTURES) ACT 2022*		
An interim Health Plan must be in place by our commencement date 1 July 2022	This Te Pae Tata | interim New Zealand Health Plan, will be delivered to the Minister in early July 2022 to ensure a plan is in place to guide the operations of the health system from the commencement date.	

*Note: the Pae Ora (Healthy Futures) Act 2022 specifies a number of requirements for the content and process to develop a New Zealand Health Plan, which will apply to the first full New Zealand Health Plan in 2024.

Appendix Three: Performance measurement

These measurements are from Te Pae Tata, the interim Government Policy Statement on Health on Health (iGPS), Whakamaua, the Health System Indicators (HSI) and Vote Health. They are grouped against the actions outlined in Te Pae Tata.

Where available these measures will be available for different population groups to highlight equity, namely Māori, Pacific people and Tāngata whaikaha | Disabled people, and different geographical areas including rural.

Valuing the voices of consumers and whānau

SOURCE	MEASURE
iGPS	Experience of primary healthcare and adult inpatient health services measured across demographic groups using patient experience surveys.
iGPS, Whakamaua	Experience of health services for Māori as measured by the primary healthcare and adult inpatient patient experience surveys.
iGPS, Whakamaua	Feedback from the Iwi Māori Partnership Boards on how they are fulfilling their role and whether they are receiving the support they require.
HSI	People report being involved in the decisions about their care and treatment.

A strong workforce whānau

SOURCE	MEASURE
iGPS	Engagement survey of staff on culture and shift towards one team ethos, a measure will be developed.
iGPS	Number and proportion of graduates of health training programmes from demographic groups under-represented in the health workforce, compared to the demographics of the population.
iGPS, Whakamaua	Proportion of Māori and other under-represented groups in the regulated and unregulated health workforce, compared to the demographics of the total population.

Developing an inclusive leadership and culture

SOURCE	MEASURE
iGPS, Whakamaua	Number of Māori in leadership and governance roles across the Ministry of Health and health sector Crown entities.
iGPS, Whakamaua	Proportion of Māori and Pacific people in leadership and governance roles across the Ministry of Health and health sector Crown entities.

Strengthening the use of health insights and intelligence

SOURCE	MEASURE
Whakamaua	Number of kaupapa Māori research proposals receiving ethics approval that focus on Māori health and disability.

Pae ora | Better health in our communities

SOURCE	MEASURE
iGPS	Enrolment with a primary maternity care provider in the first trimester of pregnancy, reported by ethnicity and geographic area.
iGPS, HSI	Complete roll-out of the Access and Choice programme for primary mental health and addiction support services so that access is available for 325,000 people per year by the end of June 2024.
iGPS, HSI	Access to planned care.
iGPS, HSI, Vote Health	Uptake of immunisations for key age groups, reported by ethnicity and geographic area.
iGPS, HSI, Whakamaua	Rate of hospital admissions for an illness that might have been prevented or better managed in the community, reported by key age groups.
iGPS, HSI, Whakamaua	Proportion of people reporting unmet need for primary healthcare, reported by ethnicity and geographic area.
iGPS	Proportion of people waiting for planned specialist care who receive it within four months, reported by ethnicity and geographic area.
iGPS	Standardised rate of acute readmissions within 28 days of discharge, reported by ethnicity and geographic area.
HSI	Reducing bowel cancer incidence – developmental measure.
HSI	Participation in bowel screening programme – mandatory contributory measure.

Kahu Taurima | Maternity and early years

SOURCE	MEASURE
iGPS	Enrolment with a primary maternity care provider in the first trimester of pregnancy, reported by ethnicity and geographic area.
iGPS, HSI	Uptake of immunisations for key age groups, reported by ethnicity and geographic area.
iGPS, HSI, Whakamaua	Ambulatory sensitive hospitalisations for children aged 0-4.

Mate pukupuku | People with cancer

SOURCE	MEASURE
iGPS	Proportion of people who start first treatment for breast, cervical and bowel cancer after a screening result shows presence of cancer, reported by ethnicity and geographic area.
iGPS	Variation of clinical prioritisation for cancer treatment and elective surgery, reported by ethnicity and geographic area.
HSI	Reducing bowel cancer incidence – developmental measure.
HSI	Participation in bowel screening programme – mandatory contributory measure.

Māuiuitanga taumaha | People living with chronic health conditions

SOURCE	MEASURE
iGPS, Whakamaua	Rate of diabetes complications, reported by ethnicity and geographic area.
Vote Health	Percentage of stroke patients referred for community rehabilitation who are seen face to face by a member of the community rehabilitation team within seven calendar days of hospital discharge.

Oranga hinengaro | People living with mental distress, illness and addictions

SOURCE	MEASURE
iGPS	Complete roll-out of the Access and Choice programme for primary mental health and addiction support services so that access is available for 325,000 people per year by end of June 2024.
iGPS, HSI, Whakamaua	People under 25-years able to access specialist mental health services within three weeks of referral.
iGPS	Percentage of spend of HNZ total budget on mental health.
HSI	Access to primary mental health and addiction services – developmental measure. Initial reporting of data from integrated primary mental health and addiction services.

Mechanisms to develop a unified health system

SOURCE	MEASURE
iGPS	Proportion of entities or services that have been assessed against the Consumer Engagement Quality and Safety Marker; and of those, the proportion that have been assessed at Level 3 or 4.
iGPS, Whakamaua	Health entity spending on Māori health service providers.
iGPS, Whakamaua	Geographical coverage and utilisation of Rongoā Māori services.

An enhanced national public health system

SOURCE	MEASURE
iGPS	Percentage of spend of Te Whatu Ora total budget on public health.

Stronger primary and community care

SOURCE	MEASURE
iGPS, HSI	Uptake of immunisations for key age groups, reported by ethnicity and geographic area.
iGPS, HSI, Whakamaua	Proportion of people reporting unmet need for primary healthcare, reported by ethnicity and geographic area.
iGPS, HSI, Whakamaua	Rate of hospital admissions for an illness that might have been prevented or better managed in the community, reported by key age groups.
iGPS	Experience of health services as measured by the primary healthcare patient experience survey.
iGPS	Percentage spend of Te Whatu Ora total budget on primary and community care.
HSI	General practitioner numbers as full-time equivalents per 100,000 population – developmental measure, mandatory contributory measure.
HSI	People report being involved in the decisions about their care and treatment.

Networked hospital and specialist service delivery

SOURCE	MEASURE
iGPS	Variation of clinical prioritisation for cancer treatment and elective surgery, reported by ethnicity and geographic area.
iGPS	Missed appointments for specialist care, reported by ethnicity and geographic area.
iGPS, HSI, Whakamaua	Variation in the rates of access to key identified services by ethnicity, geographic area and other characteristics. Initial areas include surgery, first specialist assessments, gender affirming care, colonoscopies, access to specialist mental health, including for rangatahi, and screening.
iGPS	Standardised rate of acute readmissions within 28 days of discharge, reported by ethnicity and geographic area.
iGPS	Percentage of people waiting for planned specialist care who receive it within four months.
iGPS	Experience of health services as measured by the adult inpatient patient experience survey.
iGPS	Percent spend of HNZ total budget on specialist and hospital services.
iGPS, Whakamaua	Did not attend and Did not wait percentages for Māori at outpatient services, including a comparison between percentages for Māori and non-Māori, non-Pacific.
HSI	Equitable reduction in standardised rates of intervention.
HSI, Whakamaua	Equitable reduction in standardised rates of acute bed days.

Strengthening our system enablers

SOURCE	MEASURE
iGPS	Proportion of medical appointments completed through digital channels, initially for outpatients and expanding to include GP appointments when data is available.
iGPS	Develop an Investment Strategy and National Asset Management Strategy by December 2023.

Māori health improvement

SOURCE	MEASURE
iGPS, Whakamaua	Funding received by kaupapa Māori health and disability service providers.
iGPS, Whakamaua	Geographical coverage and utilisation of Rongoā Māori services.
iGPS, HSI, Whakamaua	The percentage of Māori reporting unmet need for primary healthcare, including a comparison between Māori and non-Māori, non-Pacific.
iGPS, Whakamaua	Experience of health services as measured by the primary healthcare and adult inpatient patient experience surveys.
iGPS, Whakamaua	Did not attend and Did not wait percentages for Māori at outpatient services, including a comparison between percentages for Māori and percentages for non-Māori, non-Pacific.
iGPS, Whakamaua	Percentage of Māori in the regulated workforce compared with the percentage of Māori in the population.
iGPS, HSI, Whakamaua	Rates of ambulatory sensitive hospitalisations (ASH) for Māori aged 0-4-years, including a comparison with rates for non-Māori, non-Pacific.
iGPS, Whakamaua	Māori young people able to access specialist mental health or addiction services in a timely manner within three weeks from referral, including a comparison between access for Māori and access for non-Māori, non-Pacific.
iGPS, Whakamaua	Rate of diabetes complications for Māori compared with non-Māori, non-Pacific.
iGPS, Whakamaua	Measures of the health of Māori-Crown partnerships being developed by Office for Māori Crown Relations – Te Arawhiti, as evidenced in the health and disability system.
Whakamaua	Number of kaupapa Māori research proposals receiving ethics approval that focus on Māori health and disability.
iGPS, Whakamaua	Number of Māori in leadership and governance roles across the Ministry of Health and health sector Crown entities.
HSI, Whakamaua	Standardised acute bed days per capita for Māori, including a comparison between Māori rates and rates for non-Māori, non-Pacific.
iGPS	Proportion of Māori and Pacific people in leadership and governance roles across the Ministry of Health and health sector Crown entities.
iGPS	Percentage spend of Te Whatu Ora total budget on hauora Māori services.

Pacific health

SOURCE	MEASURE
iGPS, Whakamaua	Proportion of Māori and Pacific people in leadership and governance roles across the Ministry of Health and health sector Crown entities.

Other key measures

There are two measures which are relevant across the whole of Te Pae Tata.

SOURCE	MEASURE
iGPS	Health entities are clear about their own and other entities' roles and responsibilities, and are delivering to these.
iGPS	Develop and monitor an agreed measure of quality-adjusted, system-level productivity.

Presented to the House of Representatives pursuant to section 53(5)(a) of the Pae Ora (Healthy Futures) Act 2022

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Ā mātou whakapapa | Our narrative

In the pūrakau (ancient legend), when Tāwhaki ascended into heaven to attain the three baskets of knowledge, he also collected two mauri stones named 'Hōkai nuku' and 'Hōkai rangi'. These stones were seen as supporting the three baskets of knowledge, with one having the ability to look back into the past, while the other provided a vision into the future.

Watch Rahui Papa talk about Ā mātou whakapapa. https://www.tewhatuora.govt.nz/about-us/who-we-are/our-story/

Te Whatu Ora – tohu

Read about the meaning behind our tohu – tāniko (shown above). https://www.tewhatuora.govt.nz/about-us/who-we-are/our-story/

Te Aka Whai Ora – tohu

Read about the meaning behind our tohu – Te hau (shown below). https://www.teakawhaiora.nz/a-matou-whakapapa-our-narrative/

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Te Kāwanatanga o Aotearoa
New Zealand Government

Health New Zealand Board Governance Manual

CONTENTS

1. Introduction

Health New Zealand (Health NZ) is a Crown agent established under section 11 of the Pae Ora (Healthy Futures) Act 2022 (Pae Ora Act).

The Pae Ora Act sets the framework for New Zealand's public health system. The purpose of the 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 in health outcomes among New Zealand's population groups, including by striving to eliminate health disparities, in particular for Māori; and

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

The purpose of the Act guides all actions of Health NZ.

[Refer Pae Ora Act s 3]

1.1 Scope of the governance manual

The Health NZ Board (the Board) is responsible for the governance of Health NZ. Governance includes the processes by which organisations are directed, controlled and held to account. Crown entity governance is different from governance in the private or not-for-profit sectors. Governance in the State sector has added obligations and complexities derived from the ethos of public service, the Ministerial role and relationships, and the impact that Crown entities have on individuals, business and communities in New Zealand.

Every statutory Crown entity is expected to have a board governance manual that reflects good practice standards. The purpose of this governance manual is to provide an overview of the Health NZ Board's statutory duties and the governance principles for the Board's performance, so that board members have the relevant knowledge, information and reference material to be part of an effective, skilled and committed board.

1.2 Principal sources for Manual

This Manual is primarily based on Health NZ's legal obligations under the Crown Entities Act 2004, the Pae Ora Act, the Public Service Act 2020, and includes the guidance produced to promote compliance with those obligations, in particular the Public Service Commission's Resource for preparation of Governance Manuals (Guidance for Statutory Crown Entities) (2014) (PSC Guidance) to the extent they are current and relevant. This Manual lists references to these sources so that readers can locate the relevant provisions for further detail, noting that specific legal and governance advice may be requested to support the Board at any time.

1.3 Manual revision history

The Board Secretariat keeps a revision history and of Board approvals of any changes to this Manual. When approved changes occur, copies of the revised Manual are provided to all persons referenced to receive a copy of the Manual.

Version	Updated by	Reason for revision	Date
V1.0	Board Secretariat	N/A	1 July 2022

2. Governance, functions and powers

2.1 Statutory framework

The key legislation applicable to Health NZ is:

- Crown Entities Act 2004 (CE Act)
- Pae Ora (Healthy Futures) Act 2022 (Pae Ora Act)
- Medicines Act 1981
- Health Act 1956
- Public Service Act 2020
- Public Finance Act 1989
- Official Information Act 1982
- New Zealand Bill of Rights Act 1990
- Privacy Act 2020
- Protected Disclosures Act 2000 (as amended in 2009)
- Public Records Act 2005
- Health and Safety at Work Act 2015.

Health NZ also needs to comply with Government Policy Statements where they apply to Crown entities (e.g., the Government Workforce Policy Statement), the Health Information Privacy Code 2020 as well as other general laws where relevant (for example employment and pay equity legislation, the Commerce Act 1986, Human Rights Act 1993, climate change and financial markets legislation). In addition to legislation, there are key letters of expectations from the Ministers and public sector guidance.

2.2 Health NZ is a Crown agent

Health NZ is a Crown agent under the CE Act.[1] As a Crown agent, Health NZ must give effect to government policy that relates to Health NZ's functions and objectives when directed by the Minister of Health. Health NZ must also comply with directions to support the whole-of-government approach from the Minister for the Public Service and the Minister of Finance, and with the reporting requirements in the CE Act.

Health NZ's Responsible Minister is the Minister of Health (referred to as 'the Minister' throughout this Manual). Its Monitor is the Ministry of Health (the Ministry). The Māori Health Authority and Treasury also have monitoring roles (see 3.4 and 3.7).

The CE Act prevails over the Pae Ora Act unless the Pae Ora Act expressly provides otherwise.

[Refer CE Act ss 4, 7, 27, 27A, 103 and 107, Part 4 and Sch 1; Pae Ora Act s 11, PSC Guidance, Chapter 1, p 5]

2.3 Health NZ's functions, objectives, and powers

Health NZ can only do things for the purpose of performing its functions as described in the Pae Ora Act. The functions of Health NZ are to:

[1] Health NZ is a statutory entity listed in Part 1 of Schedule 1 of the CE Act – therefore it is a Crown agent, as opposed to being and autonomous or independent Crown entity.

(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
(fa) undertake health workforce planning; and
(fb) collaborate with relevant entities to improve the capability and capacity of the health workforce; and
(g) undertake and promote public health measures, including commissioning services to deliver public health programmes specified by the Public Health Agency; and
(h) improve service delivery and outcomes for all people at all levels within the publicly funded health sector; and
(i) collaborate with other agencies, organisations, and individuals to improve health and wellbeing outcomes and to address the wider determinants of health 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 6 of the Pae Ora Act; and
(l) engage with iwi-Māori partnership boards; and
(m) evaluate the delivery and performance of services provided or funded by Health NZ; and
(n) provide accessible and understandable information to the public about services funded by Health NZ; and
(na) undertake and support research relating to health; and
(o) provide, or arrange for the provision of, services on behalf of the Crown or any Crown entity within the meaning of the CE Act; and
(p) perform or exercise the functions, duties, and powers conferred or imposed on it by the Pae Ora 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 CE Act.

In performing its functions, Health NZ must act consistently with its objectives, which are:

(a) to design, arrange, and deliver services to achieve the purpose of the Pae Ora Act in accordance with the health sector principles; and
(b) to encourage, support, 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 agencies, organisations, and individuals to address the determinants of health.

Health NZ must give effect to the Government Policy Statement on Health and the New Zealand Health Plan when performing its functions and, in performing any of its functions in relation to the supply of pharmaceuticals, it must not act inconsistently with the pharmaceutical schedule.

Health NZ may do anything authorised by the CE Act or the Pae Ora Act and anything a natural person of full age and capacity may do (natural powers) – but all such things may only be done for the purpose of performing its functions. In addition, the CE Act contains some specific constraints on

the exercise of natural powers, constraints on bank accounts, and limits on powers to indemnify and insure.

[Refer Pae Ora Act, ss 13 and 14; CE Act, ss 14(2), 16-19, 112, 117, 158, 163]

2.4 Te Tiriti o Waitangi / Treaty of Waitangi

Te Tiriti is New Zealand's founding constitutional document. The Pae Ora Act provides for the Crown's intention to give effect to the principles of te Tiriti o Waitangi (the Treaty of Waitangi) in the health sector. As specifically relevant to Health NZ, the Pae Ora Act:

- requires Health NZ to be guided by the health sector principles (see below)
- establishes the Māori Health Authority and requires Health NZ to work with it
- requires a Hauora Māori Strategy to be jointly prepared by the Māori Health Authority and the Ministry and set by the Minister, and requires Health NZ to have regard to it
- provides for iwi-Māori partnership boards to have a meaningful role in the planning and design of local services, and requires Health NZ to engage with iwi-Māori partnership boards
- requires the Government Policy Statement (to which Health NZ must give effect) to contain priorities for hauora Māori
- requires Health NZ and the Māori Health authority to jointly develop and implement the New Zealand Health Plan
- requires that the Health NZ Board have, collectively, knowledge of, and experience and expertise, in relation to, te Tiriti o Waitangi and tikanga Māori
- requires that the Board maintain systems and processes to ensure that Health NZ has the capacity and capability to understand te Tiriti o Waitangi, mātauranga Māori, and Māori perspectives of services.

[Refer Pae Ora Act s 6]

2.5 The health sector principles

When performing a function or exercising a power or duty under the Pae Ora Act, Health NZ must be guided by the health sector principles as far as reasonably practicable having regard to all the circumstances, including any resource constraints, and to the extent applicable to them.

For the purposes of the Pae Ora Act, the health sector principles are:

(a) the health sector 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 sector 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 improve hauora Māori outcomes

(c) the health sector 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 sector should provide choice of quality services to Māori and other population groups, including by:
    (i) resourcing services to meet the needs and aspirations of iwi, hapū, and whānau, and Māori (for example, kaupapa Māori and whānau-centred services); and
    (ii) providing services that are culturally safe and culturally responsive to people's needs; and
    (iii) developing and maintaining a health workforce that is representative of the community it serves; and
    (iv) harnessing clinical leadership, innovation, technology, and lived experience (meaning the direct experience of individuals) to continuously improve services, access to services, and health outcomes; and
    (v) providing services that are tailored to a person's mental and physical needs and their circumstances and preferences; and
    (vi) providing services that reflect mātauranga Māori

(e) the health sector 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; and
    (iv) collaborating with agencies and organisations to address the wider determinants of health; and
    (v) undertaking promotional and preventative measures to address the wider determinants of health, including climate change, that adversely affect people's health.

[Refer Pae Ora Act s 7]

2.6 Health NZ's Board

Health NZ is governed by a Board of up to eight Members appointed by the Minister under the CE Act and Pae Ora Act. The Board is the governing body of Health NZ, with the authority to exercise Health NZ's statutory powers and perform its functions. The Board may only act to perform Health NZ's statutory functions.

Board Members are accountable to the Minister for the performance of their collective duties and to Health NZ and the Minister for the performance of their individual duties (see section 4.2).

[Refer ss 25, 58 and 59 CE Act, Pae Ora Act s 12]

The CE Act, the Pae Ora Act, the Public Service Act 2020 and the Public Finance Act 1989 govern the Board's governance role, and include the following key elements:

- maintaining appropriate relationships with the Minister, the House of Representatives and the public
- ensuring Health NZ performs its function efficiently and effectively, acts consistently with its objectives and complies with all legal obligations, Health NZ's accountability documents and relevant Crown expectations)

- ensuring that Health NZ is a good employer and ensures the fair and proper treatment of employees in all aspects of their employment, including providing good and safe working conditions
- setting strategic direction
- ensuring all employees maintain proper standards of integrity, conduct and concern for the public interest
- upholding the five public service principles (*politically neutral, free and frank advice to Ministers, merit-based appointments, open government* and *stewardship*) when carrying out Health NZ's functions
- preserving, protecting, and nurturing the spirit of service to the community that public service employees bring to their work
- ensuring that Health NZ acts in a financially responsible manner, prudently managing its assets and liabilities to ensure its long-term financial viability
- appointing the Chief Executive of Health NZ
- monitoring the performance of Health NZ and of its Chief Executive.

The Board also must ensure that Health NZ maintains policies and procedures consistent with the Public Service Commission's Code of Conduct for Crown Entity Board Members, which is binding on Health NZ.

The Board delegates Health NZ's day-to-day leadership and management to the Chief Executive. This includes matters relating to Health NZ's responsibilities as an employer (see section 6.2).

The Board or its authorised delegate must make all decisions relating to Health NZ's operation.

[Refer CE Act, ss 14, 16, 17, 25, 26, 117, 118 and 170; Public Service Act, ss12 and 13, PSC Guidance, Chapter 2]

3. Key relationships

3.1 Relationship with the Minister

The Minister oversees and manages the Crown's interest in, and relationship with, Health NZ. The Minister has statutory powers regarding Health NZ's strategic direction, targets, funding, performance expectations, monitoring, reporting and reviews. The Minister has the ability to appoint Crown observers, dismiss the Board or appoint a commissioner, or require an improvement plan.

The Minister has a statutory power to request the following information from the Board:

- any information relating to the operations and performance of Health NZ
- any information in connection with the exercise of their powers relating to Health NZ's reporting and financial obligations.

Under the CE Act, the Minister for the Public Service may require the Board to supply information to assess the capabilities and performance of the public service.

The Board should note that the Minister of Finance and the Director General of Health may require Health NZ provide certain information under the Pae Ora Act.

The Board is also expected to adopt a "no surprises" approach to its relationship with the Minister (see below).

[Refer CE Act, ss 27, 27A, 133 and134, Part 4; Pae Ora Act ss 61-66]

3.2 "No surprises" approach

The Board is expected to engage constructively and professionally with the Minister, which is enhanced when there is a free flow of information both ways, by regular formal and informal reporting and discussion, and through an open and trusting relationship.

The enduring letter of expectations from Ministers to Board Chairs of Crown entities (see Enduring-Letter-of-Expectations-to-statutory-Crown-entities-2019.pdf (publicservice.govt.nz) expects Board Chairs to inform their Minister promptly of matters of significance within his or her portfolio responsibilities, particularly where these matters may be controversial or may become the subject of public debate, i.e. a "no surprises" approach. Any protocols adopted in this respect need to recognise that what a board considers to be "business as usual" may be seen by the Minister to come within the requirement of "no surprises".

"No surprises" means that the Government expects a board to:

- be aware of any possible implications of their decisions and actions for wider government policy issues
- advise the Minister of issues that may be discussed in the public arena or that may require a ministerial response, preferably ahead of time or otherwise as soon as possible
- inform the Minister in advance of any major strategic initiative.

[Refer CE Act, ss 27, 27A, 133 and134]

3.3 Relationship with the Chief Executive and Health NZ staff

All decisions relating to the operation of Health NZ must be made by, or under the authority of, the Board in accordance with the CE Act and the Pae Ora Act.

Where a Chief Executive has been employed, the management responsibilities within a Crown entity are usually delegated to the Chief Executive. It is important that the Board and the Chief Executive are clear about the boundaries between governance and management and what duties have been delegated to the Chief Executive.

The Board respects that the role of the Board and Committees is one of governance. The Board delegates authority to the Chief Executive to be responsible for day-to-day management and implementation of Health NZ's functions, subject to any limitations on the Chief Executive (and therefore all Health NZ employees) that the Board determines.

Primarily the key point of contact for the Board, and through the Chair, is the Chief Executive. In relation to Board Committees, the Chair will likely have a direct relationship with the relevant executive/s without the need to involve the Board Chair.

While the relationship between the Minister and the Board is through the Chair, the Chief Executive and some other senior staff will also have relationships with Ministers. Board Members and the Chief Executive must be clear about who has contact with the Minister and the Minister's office. Where a Chief Executive or other senior staff meet regularly with the Minister, protocols should be set in place around this, including feedback given to the Board on all meetings.

The Chair and the Chief Executive and others to be determined by the Chief Executive on an as needed basis are the public face of Health NZ.

The Chief Executive and other senior managers of Health NZ are likely to be in regular attendance at meetings of the Board and its committees; when and how often is a matter for the Board and/or each committee to decide.

Board Members may also wish to meet with senior managers and staff to assist with their understanding of the organisation and its operation. Protocols on how Board Members engage with staff should be in place because staff members may misunderstand a Board Member's statements on a matter as a direction and therefore give undue priority to those comments over other work requirements. When contacting Health NZ employees, Board Members are expected to act in a manner consistent with their governance role and not seek to become involved in operational and management matters.

[Refer CE Act, s 25]

3.4 Relationship with the Māori Health Authority

The Health NZ and Māori Health Authority Boards will work in partnership, in accordance with Te Pae Ora Legislation.

The Pae Ora Act requires Health NZ to work with the Māori Health Authority when performing specific functions (see 2.3) and requires the two entities to jointly prepare some reports (see 8.2).

One of the Māori Health Authority's functions is to monitor the delivery of hauora Māori services by Health NZ and provide public reports on the results of that monitoring.

[Refer Pae Ora Act, s 14(1)(l), s 19(k)-(l)]

3.5 Relationship with iwi-Māori partnership boards (IMPBs)

The Pae Ora Act requires Health NZ to engage with IMPBs and to provide them with sufficient and timely information to support them in achieving their purpose.

IMPBs will engage with whānau and hapū about local health needs and communicate the results and insights from that engagement to Health NZ and the Māori Health Authority. They will also work with both entities in agreeing to locality plans for a relevant locality.

[Refer Pae Ora Act, ss 6, 14, 15, 30]

3.6 Relationship with the Ministry of Health

The Ministry of Health is the monitoring department for Health NZ. As the monitoring department, the Ministry acts as an agent for the Minister, providing the Minister with information, analysis and advice on Health NZ's effectiveness and efficiency.

The Ministry's role includes:

- monitoring performance against expected results and outputs
- advising the Minister regarding Health NZ's capability to achieve desired results
- ensuring there are appropriate and timely Board Member appointments, inductions and governance exercised over Health NZ.

[Refer CE Act, s 27A and publicservice.govt.nz/guidance-depts-crown-entities-may06]

3.7 Other agencies with a monitoring role

In addition to the role of the Ministry of Health and the Māori Health Authority in monitoring Health NZ, there are other agencies who will monitor Health NZ for different purposes. Treasury will play a key role in monitoring Health NZ's performance and financial management. Other monitors include the Health Quality and Safety Commission around clinical governance and Health NZ's quality settings and maturity. There are other entities, such as WorkSafe, the Ombudsman and the Privacy Commissioner who act as monitors or regulators for specific matters.

3.8 Parliamentary Select Committees

Health NZ is accountable to the House of Representatives. One mechanism for scrutiny is through parliamentary select committees. The most regular contact Health NZ is likely to have with select committees is for financial reviews, inquiries, and occasionally when making submissions on bills. Board Members should be particularly aware of:

- Examination of the estimates: The estimates are the Government's request for appropriations/authorisation for the allocation of resources, tabled on Budget day. Crown entities do not attend the select committee when it examines the estimates, but responsible Ministers and monitoring departments may be questioned about the intended activities and expenditure of an entity that receives appropriations from the Crown.
- Financial review: The financial review is of the entity's performance in the previous financial year and of its current operations. The review can include any public organisation, whether or not it receives appropriations from the Crown. The select committee will provide written questions for answer, but if the entity is asked to appear, further questions may be asked on the day.

Board Members and Health NZ staff who appear before a select committee do so in support of ministerial accountability. Generally, the Chair and the Chief Executive will represent Health NZ at select committee hearings although this is a matter for the Board to decide. The Board is answerable to the responsible Minister, who is in turn accountable to the House of Representatives for the operations of Health NZ.

Representatives of Health NZ appearing before select committees have an obligation to manage risks and avoid springing surprises on the Minister. This applies even when they appear on matters which do not involve ministerial accountability, such as when exercising an independent statutory responsibility or appearing in a personal capacity. Board Members and employees who wish (or are invited) to make a submission to a select committee on a bill on behalf of Health NZ are expected to discuss the matter with the Minister.

The Public Service Commission's Officials and Select Committee Guidelines (2007) provides guidance on appearing before select committees. Board Members and employees of Crown Entities are considered "officials" for the purposes of those Guidelines.

[Refer CE Act, s 3, Public Service Commission publicservice.govt.nz/officials-and-select-committees-2007.]

4 Conduct of Board Members

4.1 Code of Conduct

The Public Service Commissioner has issued a Code of Conduct that applies to the staff of Crown entities. Board Members are expected to comply with the standards of integrity and conduct set out in the Code of Conduct, at all times.

[Refer Public Service Commission: Code of Conduct for Crown Entity Board Members]

4.2 Fundamental duties and obligations

Individual duties of Board Members

Board Members must comply with the law, and in particular with all obligations and duties in the CE Act and Pae Ora Act. Board Members' individual duties are owed to both Health NZ and the Minister. The specific individual duties of Board Members set out in sections 53-57 of the CE Act are:

- **to comply with the CE Act and Pae Ora Act**; Board Members must not contravene, cause the contravention of, or agree to Health NZ contravening the CE Act or Pae Ora Act
- **to act with honesty and integrity**; Board Members must, when acting as Board Members, act with honesty and integrity
- **to act in good faith and not at the expense of Health NZ's interests**; Board Members must, when acting as Board Members, act in good faith and not pursue their own interests at the expense of Health NZ's interests
- **to act with reasonable care, diligence and skill**; Board Members must, when acting as Board Members, exercise the care, diligence and skill that a reasonable person would exercise in the same circumstances, taking into account (without limitation) the nature of Health NZ, the nature of the actions and the positions of the Board Members and the nature of their responsibilities
- **to not disclose information**; a Board Member who has information in their capacity as a Board Member that would not otherwise be available to them must not disclose that information to any person, or make use of, or act on, that information except as provided in the CE Act.

[Refer CE Act, ss 53 – 57 and 59; PSC Guidance, Chapter 4, pp 16-17]

Collective duties of the Board

The Board has collective duties under both the CE Act and the Pae Ora Act. Collective duties are owed to the Minister. Individual Board Members are not legally liable for a breach of a collective duty. If the Board does not comply with these duties all or any of the Board Members may be removed from office.

The collective duties in section 16 of the Pae Ora Act, are to ensure that Health NZ:

a) acts in a manner consistent with the Government Policy Statement and the NZ Health Plan
b) works collaboratively with the Māori Health Authority
c) operates in a financially responsible manner and, for that purpose, endeavours to cover all its annual costs (including the cost of capital) from its net annual income
d) maintains systems and processes to ensure that Health NZ:
    i) has the capacity and capability to perform its functions; and

ii) has the capacity and capability to understand te Tiriti o Waitangi, mātauranga Māori, and Māori perspectives of services.

The collective Board duties in the CE Act are:

- to ensure that Health NZ acts consistently with its objectives, functions, Statement of Intent and service and performance agreement (to become statement of performance expectations)
- to ensure that the Board functions are performed efficiently, effectively and in a manner consistent with the spirit of service to the public and in collaboration with other public entities if practicable
- to ensure that Health NZ operates in a financially responsible manner (including in the prudent management of its assets and liabilities and the assurance of its long-term financial viability and status as a successful going concern)
- to ensure that Health NZ upholds the public service principles when carrying out its functions
- to preserve, protect, and nurture the spirit of service to the community that public service employees bring to their work
- to ensure that Health NZ subsidiaries comply with the rules set out for subsidiaries in the CE Act (see section 7).

[Refer CE Act, ss 49-52 and 58; Pae Ora Act, s 16; PSC Guidance, Chapter 4, pp 16-17]

4.3 Official Information Act

Health NZ is subject to the Official Information Act 1982 (OIA) which allows people to request official information held by a range of public bodies and organisations, including Crown entities. The key principle is that information will be made available (in response to a request or proactively) unless there is a good reason, as defined in the OIA, for withholding. Agencies must balance the public interest in disclosing information against the need to withhold it. If the public interest in disclosure outweighs the need to withhold the information, then it must be released. Where the need to withhold for commercial, privacy or legal or other grounds under the OIA outweighs the public interest, the information will be withheld. This may involve balancing public interests and privacy or withholding legally privileged advice.

Material produced by or for the Board, including meeting agenda, minutes, reports, and communications is official information that may be subject to disclosure under the OIA. Board Members need to recognise that what they say or write could be disclosed under an OIA request.

See the Official Information Act policy [link to come] which applies to all Health NZ staff and to Board Members.

4.4 Proactive release of information

Proactive release is the other face of information-sharing, where agencies publish official information (usually on the internet) without being asked for it, to enable transparency, strengthen accountability and improve public trust and confidence. Information of public interest and information that is frequently requested via the OIA will be considered for proactive release on the Health NZ website in accordance with the timeframes established in the Proactive Release Policy [link to come]

Proactive release is different from releases under the OIA. It is a decision of the Board or Chief Executive to release the information in the interests of transparency. It therefore does not have the same protections from sanctions that apply to information released under the OIA (section 48).

In addition to the normal assessments for releasing official information, a risk assessment will be carried out to address the issue that protections from civil or criminal liability are not available when proactively releasing official information.

4.5 Board Information Privacy Responsibility

In the course of Board work, Board Members will often have access to information which is commercially sensitive or valuable or may be personal information about an individual/s. To ensure the Board and Health NZ are trusted, this information needs to be handled with the highest standards of care and integrity and in a manner consistent with the relevant legislation.

Information about an identifiable individual is protected by the Privacy Act 2020. The information does not need to name the individual, as long as they may be identifiable in other ways. The Privacy Act sets principles that guide how we can collect, store, use and disclose personal information, as well as giving people the right to access and correct their information. See the Privacy Policy [link to come] which applies to all Health NZ staff and to Board Members.

The following principles apply when handling information: under section 57 of the CE Act, Board Members must not disclose to any person or make use or act on information they receive as a member and to which they would not otherwise have had access, unless:

- in the performance of Health NZ's functions
- as required or permitted by law (for example, in accordance with the OIA)
- in complying with the requirement for the member to disclose their interests
- where the member has been authorised by the Board or by the Minister to disclose the information
- if the disclosure, use, or act in question will not prejudice Health NZ or will be unlikely to do so
- if the information is about an identifiable person, one of the exceptions of Information Privacy Principle 11 of the Privacy Act applies. For example, if the individual has authorised the disclosure or if the disclosure is necessary to prevent or lessen a serious threat to health and safety.

Health NZ's Privacy Officer can provide advice to the Board on any privacy matters including potential breaches.

4.6 Dealing with the public – interactions, complaints and communications

Board Members may occasionally be required to communicate with members of the public. In such circumstances, they should be very aware of the potential for perceived and actual conflicts of interest and/or perceived preferential treatment (see section 4.6 for conflicts of interest). If a Board Member becomes aware of a potential conflict of interest following any interaction, they should promptly inform the Chair.

Set out below is guidance on most interactions that a Board Member is likely to have. If a Board Member is unsure how to act in respect of interactions with members of the public, they should consult the Chair for guidance.

Complaints
If a Board Member receives a complaint or allegation or request to intervene relating to any Health NZ matter from any person, and whether the approach is written or in person, they should follow the Board Complaints Policy [draft policy ready for review].

Protected Disclosures
Board Members could be contacted concerning wrongdoing (sometimes called "whistle-blowing") that is covered by the Protected Disclosures Act 2000 or the Protected Disclosure Policy [policy to be drafted]. It is recommended that a cautious approach is taken to whether such contact is a potential protected disclosure and, that advice is taken from the Protected Disclosures Officer, the Chief Legal Officer and/or the Chair.

Board Members other than the Chair do not have an express role under the Policy, and if approached regarding matters falling under the Policy, Board Members should notify the Protected Disclosures Officer who will liaise with the Chair as appropriate.

All disclosures must be treated as strictly confidential and should be handled under the Protected Disclosure Policy, unless one of the exemptions under the Protected Disclosures Act 2000 applies.

Communications
Board Members may not comment publicly on any matter regarding Health NZ's affairs without the Chair's prior agreement. Board Member communications are governed by the Communications Policy [policy to be drafted].

If a member of the public (or a public group) seeks a response on a Health NZ matter from a Board Member, the Board Member should forward the communication to the Chair to arrange for a response on the Board's behalf. If the circumstances call for the Board Member's direct response, they should clear the response with the Chair before responding.

Select Committee Appearances
Board Members and other employees of Health NZ may represent Health NZ before a select committee. The Public Service Commission's Officials and Select Committee Guidelines (2007) provides guidance on appearing before select committees. Board Members and employees of Crown Entities are considered "officials" for the purposes of those Guidelines. Health NZ must discuss with the Minister before making a submission to a select committee.

The Chair represents the Board for annual reviews and estimates, unless the Board decides to nominate another Board Member.

[Refer Cabinet Manual 7.117]

4.7 Board Members' interests and conflicts of interest

A Board Member has a conflict of interest when they or their immediate family have an external interest that conflicts with the duties that they owe as a Board Member and the external interest does, may or may be perceived to present a risk that the Board Member will not perform their Board role impartially.

Disclosing interests
Prior to appointment, Board Members will have disclosed in writing the nature and extent of their interests in matters relating to Health NZ. Following appointment, a Board Member who is interested in a matter relating to Health NZ must disclose details of the interest to the Board Chair as

soon as practicable after the Board Member becomes aware that he or she is interested. In certain circumstances, such as where the Chair is unavailable or also has an interest in the matter, the Board Member may disclose details of the interest to the Deputy Chair, a temporary Chair, or the responsible Minister.

The details that must be disclosed are the nature of the interest and its monetary value (if it can be quantified), or the extent of the interest (if it cannot be quantified). The interests will be added to the Interests Register (see below).

A "matter" is:

a) Health NZ's performance of its functions or exercise of its powers; or
b) an arrangement, agreement, or contract made or entered into, or proposed to be entered into, by Health NZ.

A Board Member will be "interested in a matter" if he or she:

a) may derive a financial benefit from the matter; or
b) is the spouse, civil union partner, de factor partner, child, or parent of a person to whom the matter relates; or
c) may have a financial interest in a person to whom the matter relates; or
d) is a partner, director, officer, board member, or trustee of a person who may have a financial interest in a person to whom the matter relates; or
e) may be interested in the matter because the entity's Act so provides; or
f) is otherwise directly or indirectly interested in the matter.

A Board Member is not "interested" in a matter if:

a) the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence him or her in carrying out his or her responsibilities under the CE Act or another Act
b) he or she receives remuneration or other benefits authorised under the Crown Entities Act or another Act; or
c) only because of their past or current involvement in the relevant sector, industry, or practice.

[Refer CE Act, s 62-64 and 66-68; PSC Guidance, Chapter 7, pp 22-24, Public Service Commission Code of Conduct]

Interests Register

The Board Secretariat is responsible for maintaining the Interests Register. The Register is uploaded into Diligent as part of each meeting pack. It remains confidential to the Board, the Chief Executive, and relevant members of the Board Secretariat supporting the Board and Committees. It will not be disclosed to any third party unless the Chair authorises disclosure in writing.

The Board Secretariat will endeavour to ensure Board Members do not receive information relating to matters in which the Board Members have declared interests thereby mitigating a conflict arising.

Register of Conflicts of Interest

The Interest Register is separate to the Register of Conflicts of Interest [still to come]. The registers are confidential and should not be disclosed to any third party unless first authorised in writing by the Chair. But as it is required by statute, its disclosure is likely to be requested under the OIA. It may also be requested by other State sector bodies, including Treasury, or by select committees. The Registers of Interest will be made available to members of the Board Secretariat and other Health NZ

employees where needed to support the Board and its processes, so they are able to follow any plans for identifying and managing conflicts that have been put in place, such as restrictions on information going to particular Board Members.

The Chair is responsible for managing conflicts of interest as and when they are notified by Board Members or the Board Secretariat. The Register of Conflicts of Interest is normally noted as one of the first agenda items for each Board or Committee meeting. Under this agenda item the Board has adopted the practice of confirming if any items of actual, potential or perceived conflict have been identified in the material provided for consideration at the meeting.

When a conflict or potential conflict of interest arises in a meeting and that conflict of interest has not been previously notified to the Chair or other Board Members, this must be disclosed to all Board Members immediately and the Board Member concerned must withdraw from the meeting while the matter is discussed. The Board Member must not vote on the matter. If such notification and withdrawal occur, they must be included in the Register of Conflicts of Interest and will be noted in the Board minutes.

The Board Secretariat will prompt a quarterly review by all Board and external Board Committee Members of their interests. Board Members should also maintain a process of review of their interests and must ask the Board Secretariat to make amendments to the Interest Register as required.

[Refer CE Act, ss 63-65; PSC Guidance, Chapter 7, pp 22-27]

Consequences of conflicts of interest

A Board Member who is interested in a matter:

a) must not vote or take part in any discussion or decision relating to the matter, or otherwise participate in any activity that relates to the matter; and

b) must not sign any document relating to the entry into a transaction or the initiation of the matter; and

c) is to be disregarded for the purpose of forming a quorum for any part of a Board or committee meeting of the Board or committee during which the matter is discussed or decisions are made.

If an actual or potential conflict of interest has been identified, Health NZ will ensure that, if necessary, the Board Member is provided with redacted minutes and Board papers that exclude material related to the matter in which the Board Member is interested.

The Chair may, by prior written notice, give permission for Board Members to act in a matter in which they are interested if the Chair is satisfied that it is in the public interest to do so. Permission to act despite a conflict of interest arising must comply with the following procedure:

- written notice is provided to all Board Members before any relevant meetings
- the notice must include all relevant conditions that apply to any permitted action
- the Board minutes and Health NZ's Annual Report must contain full disclosure of the matter, the Board Member's interest and the permission to act.

[Refer CE Act, ss 66-68; PSC Guidance, Chapter 7, pp 26-27]

Chair

If a conflict of interest arises in respect of the Chair, the Chair must disclose the full details of the interest (as set out above) to the Deputy Chair or temporary Deputy Chair as soon as practicable after the Chair becomes aware that the conflict of interest exists. The Chair must ensure that the conflict of interest is entered into the Register of Conflicts of Interest. If there is no Deputy Chair or Temporary Deputy Chair (or that person is also interested in the matter), the disclosure must be made to the Minister.

The Deputy Chair (or the Minister if the Deputy Chair or Temporary Deputy Chair is unavailable or interested in the matter) is responsible for managing the Chair's conflicts of interest. The Deputy Chair or Temporary Deputy Chair (or Minister if applicable) may give permission for the Chair to act in a matter in which they are interested as long as they provide written notice to all Board Members before any relevant meetings. The written notice must include all relevant conditions that apply to any permitted action. Full disclosure of the matter and the Chair's interest and permission to act must be detailed in the Board minutes, as well as Health NZ's Annual Report.

[Refer CE Act, s 68 and Sch 5, cl 5]

Board Committees

All members of Board Committees, including external Board Committee Members, must comply with this section's rules in respect of conflicts of interest management and any disclosures must be made to both the Board Committee and the Board. Further details regarding Board Committees are discussed in section 5.3.

[Refer CE Act, Sch 5, cl 15]

Breach of Conflict of Interest Rules

If there is a failure to observe the statutory conflict of interest rules (specifically sections 63 and 66 of the CE Act), the Board must notify the Minister as soon as practicable. Where a Board Member has breached section 55 of the CE Act, they could be removed from office and Health NZ may have grounds to avoid the act in question.

[Refer CE Act, s 67]

Office of the Auditor-General Guidelines

For more information, see the Office of the Auditor-General's (OAG) "Managing Conflicts of Interest: a guide for the public sector" (2020).

4.8 Disclosure and use of information

Under the CE Act, Board Members must not disclose to any persons, make use of, or act on information they receive as Board Members (and to which they would not otherwise have had access), unless it is done:

- in the performance of Health NZ's functions
- as required or permitted by law (for example, in accordance with the OIA
- in compliance with the requirement for Board Members to disclose their interests.

A Board Member may disclose, make use of or act on the information if the Board authorises the action and the action in question will not or will be unlikely to prejudice Health NZ.

As one of the functions of Health NZ is to work with the Māori Health Authority in performing many of its other functions, it will often be permissible to disclose information to the Māori Health

Authority. In doing so, the health sector principles must be considered, as should the Māori Data Sovereignty Policy [still to come]. Normal privacy requirements apply where it is personal information.

[Refer CE Act, s 57; Pae Ora Act s 14; PSC Guidance, Chapter 8, p 28]

4.9 Gifts and hospitality

The Public Service Commission expects that when gifts and benefits are accepted there will be a transparent process of registration and declaration. It is critical to maintaining public confidence that the integrity and motivations of Board Members are not called into question.

Health NZ requires that all gifts and benefits with a value greater than $50 that are accepted by a Board Member must be disclosed through a declaration in the Gifts and Hospitality Register [still to come], which is held and maintained by the Board Secretariat.

Board Members receive the Register each month before each Board meeting to ensure that they make appropriate and timely disclosures. The Register disclosures require the recipient and donor names, the gift's estimated value, and the date received.

The Gifts and Hospitality Policy [still to come] provides detailed guidance relating to gifts and hospitality.

[Refer PSC Guidance, Chapter 9, pp 29-32]

4.10 Koha

Koha is a gift, a token, or a contribution given to an organisation on appropriate occasions, and there is often no written acknowledgement or receipt. The giving or receipt of koha should reflect the occasion. It should not be confused with other payments made by Health NZ or the organisation. To ensure consistency, any koha to be given by the Board should be approved in advance by the Chair or Deputy Chair. The receipt of koha should be declared on the Koha Register [still to come]. [TBC if there will be a Koha policy separate to gift policy]

4.11 Political neutrality

Board Members have a collective duty under the Public Service Act to ensure that they uphold the principle of political neutrality.

Board Members should, at all times, conduct themselves and their business in a manner that maintains the confidence of not only the Minister and the Government of the day, but any future Government.

Board Members must ensure that private communication with any Minister or Member of Parliament does not compromise the ability of Health NZ to operate effectively under any Government.

In the three-month period immediately preceding a general election, the Board should neither sanction nor enter into any activity, public consultation or release of information that could be interpreted as actively campaigning for, or on behalf of, a political party.

If a Board Member stands as a candidate for election to Parliament, the Board Member should stand down from their Board position on or before the day they are nominated.

Individual Board Members may be politically involved but need to be careful about how that involvement manifests itself. Board Members wishing to be involved in political activities should ensure that their activities do not undermine the confidence of the current or future Government, and do not erode public trust and confidence in Health NZ. Board Members who have been selected to stand as candidates in parliamentary elections should advise the Chair immediately, and the Chair should advise the Minister via Treasury's Commercial Operations Group. Board Members' formal political affiliations should be disclosed in the Interest Register (see section 4.7) Any matter of this nature should be raised with the Chair (or Deputy Chair if the Chair is the subject) as soon as the matter arises.

[Refer CE Act, s 30; SSC Board Appointment and Induction Guidelines, October 2015, Annex, pp 45-47; Treasury's Commercial Operations Group Owner's Expectations Manual, p 15; Minister's Letter of Expectations; see also section 3.3 Disqualification from Office; see also legal advice on guidance during election period] State Services Commission General Election Guidance and letter of expectations regarding Board Members standing for Parliament.

5 Board Activity

5.1 Board and Board Committee meeting procedures

Schedule 1 lists the Health NZ Board Committees and Schedule 2 lists the Joint Board Sub-Committees.

Meeting administration

Board meeting conduct follows standard formal meeting procedures. Meetings take place in venues and cities or virtually as determined by the Board Chair (or a Board Committee Chair for a Board Committee meeting) from time to time.

The Chair, in consultation with the Chief Executive and corporate secretariat support from the Board Secretariat, compiles the Board meeting agenda. The same process is used for Chairs of the Board Committees to agree the agendas for Board Committee meetings and may also include a relevant Executive for that Board Committee.

Any Board Member may request the addition of an item to the agenda for either a Board meeting or a Board Committee meeting. Requests for agenda additions should be directed to the Chair or Board Committee Chair.

[Refer PSC Guidance, chapter 10, pp 33-34]

Schedule and notice of ordinary meetings

The Board may determine the number of meetings held each year. An annual meeting schedule seeks to maximise the attendance of all Board Members after canvassing for availability and this process with diary appointments serve as notice of meetings.

The content for Board meetings for the year ahead is owned by the Chair and generally agreed between the Chair and the Chief Executive with any support provided from the Board Secretariat. It will ensure that business is able to be completed to meet relevant timetables and external and legislative commitments.

A Register of Board Members' attendance at meetings is maintained for inclusion in Health NZ's Annual Report.

[Refer CE Act, Sch 5, cl 7]

Board and Committee papers

Board and Board Committee meeting papers will be distributed on Diligent approximately five working days before the meeting. All papers and matters discussed at Board and Board Committee meetings are strictly confidential.

Quorum

The quorum for a Board meeting is half the number of all Board Members (if the Board has an even number of Board Members), or a majority of Board Members (if the Board has an odd number of Board Members). A Board Member who is interested in a matter must be disregarded for the purpose of forming a quorum relating to that matter. A quorum must be present to transact business at a Board meeting.

[Refer CE Act, Sch 5, cl 9 ; PSC Guidance, Chapter 10, p 32]

Special circumstances

If only one Board Member is available (for example, due to an emergency, vacancy or conflicts of interest), the Board meeting quorum will become one. When this occurs, the available Board Member:

- may appoint the times and places of ordinary Board meetings
- may call special meetings without sending notices of meeting for those meetings
- may enter into any obligation that two or more Board Members may enter into (for example section 127 of the CE Act regarding third party contracts).

[Refer CE Act, Sch 5, cl 10]

Methods of holding meetings

A quorum of Board Members may hold Board meetings at the appointed times and places.

Alternatively, they may hold a Board meeting via audio, audio and visual or electronic communication if all participating Board Members can access the required technology and a Board quorum can simultaneously communicate with each other throughout the meeting.

The Board or Board Committees may, from time to time, make decisions through unanimous written resolutions, including via electronic communication. When this occurs, the Board should copy all communications regarding unanimous decisions to the Board Secretariat for the maintenance of Board records and managing of conflicts of interest.

[Refer CE Act, Sch 5, cl 8 and 13]

Voting

Each Board Member has one vote. In addition to their general vote, the Chair has, in the case of an equality of votes, a casting vote.

Each Board Committee's Terms of Reference may contain additional voting rules.

Board resolutions are passed if all present Board Members agree without dissent, or if a majority of the votes cast on it are in favour of it.

The Board presumes that a Board Member present at a Board meeting agrees to, and votes in favour of, a resolution of the Board unless they expressly dissent or vote against the resolution at the meeting.

[Refer CE Act, Sch 5, cl 12]

Minutes
The Chair must ensure that minutes are taken at every Board and Board Committee meeting. Support will be provided for the Board and each Board Committee by the Board Secretariat.

Draft minutes and actions will be provided by the secretary of the meeting to the Chair to review. The Board and Committee Chairs are respectively responsible for ensuring that Board or Board Committee meeting minutes are taken and submitted for approval at the following meeting.

Written resolutions/out of cycle decisions
The Board may make decisions outside of Board meetings by written resolutions (out of cycle decisions). Such decisions shall be deemed to be completed and in effect when every Board Member has either approved (or provided similar clear consent, including by electronic means) or provided authorisation or their actual signature.

An out of cycle decision/written resolution may (but is not required to) be ratified at a subsequent full Board meeting. The ratification date does not alter the date that the original decision was effective from.

Role of the Board Secretariat
The Board Secretariat provides governance, legal and corporate secretariat advice and support for the Board and all Board Members. Contact details, and responsibilities of, relevant and key members of the team will be made available to all Board and Board Committee Members.

Responsibilities to support the Board include:

- enterprise-wide governance support and development of initiatives, working with the Chair and the Board to evolve and strengthen governance
- specific governance requirements or legal advisory needs, such as supporting the Board Committees. Working with the Board on evolution and continuous improvement of governance at Health NZ in line with good practises
- supporting the Chair on Board-related matters such as evaluation processes, induction and development for Board Members
- development, and running of, sustainable corporate secretariat systems and processes that implement and support this Manual such as record retention and management, active register management, appointment and onboarding processes and Board remuneration. The provision of a secretary for all Board and Board Committee meetings, including agenda preparation, minute taking and paper distribution, working with the relevant Chair
- other administrative support, including scheduling Board and Committee meetings, external visitors to the Board or from the Board, travel, accommodation, expense tracking and payment.

5.2 Delegations

The CE Act requires that the Board or someone authorised by the Board make all decisions about Health NZ's operations. If the Board delegates its powers and functions, the Board remains legally responsible for the exercise of those delegated functions and powers.

The Board may delegate its functions and powers to any of the following people by resolution and written notice to the person:

a) a member or members of the Board

b) the Chief Executive or any other employee or employees, or office holder or holders, of Health NZ
c) a committee of the Board
d) any other person or persons approved by the Minister
e) any class of persons comprised of any of the persons listed in paragraphs (a) to (d)
f) a Crown entity subsidiary of Health NZ.

Contractors and secondees may not hold delegations from the Board, unless approved by the Minister.

The Delegated Authority Policy [link to come] provides a comprehensive statement of the Chief Executive's delegations, and of Health NZ's policies and processes for ensuring that all delegated powers are properly exercised, monitored and reviewed.

The Board cannot delegate:

- its general delegation power
- any of Health NZ's statutorily independent functions to a Health NZ subsidiary
- any of its functions and powers to a Board Committee unless that Committee has a Board Member as part of its membership.

[Refer CE Act, ss 25 and 73, Sch 5; PSC Guidance, Chapter 12, p 36]

Process for Delegation
There are a number of procedural checks and balances on Board delegations, as outlined in the CE Act and the Delegated Authority Policy [link to come]. These include:

- the Board can only delegate a function or power by resolution and written notice to the delegate. The delegation can be revoked in the same way, or by any other method provided in the delegation itself
- a delegate may delegate their functions and powers only with the prior written consent of the Board, and subject to the same conditions that are attached to the delegate's exercise of those same functions and powers.

[Refer CE Act, ss 73-76; PSC Guidance, Chapter 12, pp 37-38]

Chief Executive delegation
The Board delegates much of its authority to act to the Chief Executive for day-to-day business operations. These delegations enable effective control and recognise the Chief Executive's power to delegate further the majority of the functions, duties and powers delegated by the Board. The Board may act on a matter even if it has delegated it to the Chief Executive.

5.3 Board committees

The Board may, by resolution, appoint committees:

- to advise it on any matters relating to Health NZ's functions and powers that are referred to the committee by the Board; or
- to perform or exercise any of Health NZ's functions and powers that are delegated to the committee.

The Board must ensure at least one of its members is on a committee that exercises Board powers or functions. Board committees without a Board Member may only provide advice.

All Board Committee Members (including external Board Committee) must disclose any interests in the Register of Board Members' Interests, and follow the same rules applying to Board Members in respect of the management of conflicts of interest (see 4.7).

Schedules 1 and 2 of this manual list the Board's current standing Board committees. The terms of reference for each committee sets out the functions, responsibilities, accountability, membership etc.

[Refer CE Act, ss 62-72, Sch 5, cl 14]

5.4 Board evaluation

The Board conducts an annual effectiveness review in order to evaluate Board performance. The evaluation should be made under the Board Evaluation Policy [policy being drafted].

5.5 Board Member visits to Health NZ premises

Board Member visits to Health NZ offices are welcomed. Visits may be arranged for the Board as a whole or requested by individual Board Members, depending on the circumstances. Visits to offices should only be made after prior arrangement with the Chair and in accordance with the Visits to Health NZ Premises Policy [policy being drafted].

6 Crown entities as employers

Crown entity Boards will usually employ a Chief Executive and will delegate to them responsibility for the management of the entity and the employment of other staff. Entities have obligations as employers; these are set out in the Crown Entities Act 2004 and other legislation, and in government statements.

6.1 Chief Executive employment

The employment of a Chief Executive is one of the most important things that a board does. The Board should ensure that a robust process is followed in preparing the position description, seeking suitable candidates and selecting the Chief Executive.

An entity that employs a Chief Executive must obtain the written consent of the Public Service Commissioner (usually via the Board Chair or the appointment and remuneration committee of the Board) before agreeing to or subsequently amending the terms and conditions of employment, including remuneration.

The Public Service Commission has model agreements which contain the standard terms and conditions for Chief Executives of Crown entities. Use of these model agreements is not mandatory but their use, at least as a starting point, is recommended because they incorporate good legal practice, manage risk, and are likely to make the consultation process smoother.

Chief Executive performance management

Good practice in relation to Chief Executive performance management includes:

- the Board defining the performance expectations of the Chief Executive (including stretch targets), and the criteria against which the Chief Executive's performance will be measured
- ongoing and constructive discussions between the Chair and the Chief Executive
- addressing problems early, for instance by the Chair communicating and discussing non-performance concerns; and

- a formal performance evaluation process managed by the Board Chair.

[Refer CE Act, s 117]

6.2 Board responsibility to employees

The Chief Executive of Health NZ will employ all other staff on behalf of the Board and will then be responsible for directing their work. The Board needs to delegate the appropriate level of authority to the Chief Executive to manage all operational matters. The Board has overall responsibility for the entity meeting its employment obligations.

The Board must ensure Health NZ's organisational policies comply with the principle of being a good employer. This principle includes providing:

- good and safe working conditions
- an equal employment opportunities (EEO) programme
- impartial selection of suitably qualified people for appointment
- recognition of the aims and aspirations and employment requirements of Maori and ethnic and minority groups and the employment requirements of women and persons with disabilities
- recognition of the need for the involvement of Maori as employees
- recognition of the cultural differences of ethnic and minority groups
- opportunities for the enhancement of the abilities of individual employees.

The Board must also ensure that Health NZ gives effect to the Public Service Commission's Workforce Policy Statement of the Government's expectations for employment relations in the public sector.

[Refer CE Act, s 118]

Standards of integrity and conduct
Standards of Integrity and Conduct is the code of conduct issued by the Public Service Commissioner under section 57 of the State Sector Act 1988 and continued under the Public Service Act 2020. The code is applied to all Health NZ staff and must be reflected in Health NZ's internal policies. The Code can be found at: publicservice.govt.nz/code, together with additional guidance on its interpretation and application.

Pay and employment conditions expectations
The Government's expectations of how public sector employers effectively manage employment relations is outlined in a suite of documents comprising:

- A Government Workforce Policy Statement
- The Public Service Commissioner's Public Service Pay Guidance
- The Public Service Commissioner's further advice to public sector employers.

Taken together these documents outline, amongst other things, the Government's expectations of public sector employers when negotiating employment agreements.

The Minister will require the Board to have regard to these expectations when establishing pay and employment conditions for employees.

[Refer Employment Relations | Te Kawa Mataaho Public Service Commission]

Employment Code of Good Faith

The Employment Relations Act 2000 contains a code of good faith for the public health sector (s.100D(1) and Schedule 1B), which applies to Health NZ. The code applies subject to other provisions of that Act and any other enactment that does not limit the duty of good faith in relation to the health sector. Further, the code of good faith for collective bargaining and the code of employment practice also applies in relation to the health sector (s.100D(5), Employment Relations Act 2000).

Board Health, Safety and Wellbeing Responsibility

The Health and Safety at Work Act 2015 governs health and safety practice in New Zealand. Health NZ holds a primary duty of care and obligations as a Person Conducting a Business or Undertaking (PCBU) under the Act.

Each Board Member has a positive duty to exercise due diligence to ensure Health NZ complies with its obligations and primary duty. This means each Board Member must take reasonable steps to:

a) acquire knowledge about health and safety matters
b) understand Health NZ's operations, hazards and associated risks
c) ensure Health NZ has available for use, and uses, appropriate resources and processes to eliminate or minimise risks to health and safety
d) ensure Health NZ has appropriate processes for receiving and considering information regarding incidents, hazards, and risks and for responding in a timely way to that information
e) ensure Health NZ has, and implements, processes for complying with duties; and
f) verify the provision and use of resources and processes.

The Health and Safety Board Committee will provide governance oversight to this area. Board Members are entitled to rely on this Committee and others with Health NZ, providing that reliance is reasonable, and the Board Members have enough knowledge to test advice they receive, ask the right questions and obtain the right information.

7 Subsidiaries

Health NZ may have subsidiaries, either partly or fully owned, to carry out its functions and contribute towards the achievement of its objectives. Upon establishment, Health NZ will inherit eight wholly owned Crown entity subsidiaries (not including the shared service agencies which will be wound up). HNZ must give written notice to the Minister before acquiring or forming a new subsidiary.

Health NZ is accountable for activities and performance of each subsidiary, which are reported in the parent entity's results.

[Refer CE Act, Part 2, Subpart 3]

7.1 Types of subsidiaries

"Crown entity subsidiaries" are companies that are controlled by one or more Crown entities. As per the Companies Act, essentially this is control of the composition of the Board, or greater than 50 percent of either the shareholding, right to dividends, or voting rights. A Crown entity subsidiary may

also be a multi-parent subsidiary i.e., where several Crown entities, each with less than a controlling interest, have come together to establish a company.

Each such subsidiary is a Crown entity in itself. As companies, the Companies Act 1993 applies to them, and their Board Members are directors under that Act.

Bodies that are not companies (e.g., trusts, incorporated societies or other non-company bodies), or that are associate companies (i.e., where the test for control is not met) are not Crown entity subsidiaries. Section 100 of the CE Act specifies the rules for a Crown entity acquiring such an interest. They may still be part of the Crown entity group for financial reporting purposes under the CE Act.

[Refer CE Act, ss 7,8, 100,136; Companies Act ss 5-8]

7.2 Rules that apply to subsidiaries

The provisions of the Companies Act 1993 apply to Crown entity subsidiaries as companies (except as provided in s. 102 of the CE Act). As subsidiaries are Crown entities themselves, the following applies to them:

- the provisions of the CE Act
- other legislation that is applicable to Crown entities; and
- the other chapters of this guidance.

The responsible Minister's relationship is with the parent entity rather than directly with a subsidiary. Responsible Ministers generally have no power under the CE Act to give policy, whole of government or other directions to Crown entity subsidiaries. Accordingly, ss. 97 and 98 of the CE Act set out the obligations the parent has to ensure that the subsidiary acts in accordance with the parent's functions and objectives and observes the same statutory limitations as are applied to the parent. Sections 52 and 93 of the CE Act specify that one of the collective duties of the board of a Crown entity is to ensure that it complies with ss. 96 to 101 (relating to the formation and shareholding of subsidiaries).

For multi-parent subsidiaries, the responsible Ministers of the parent Crown entities must agree how the restrictions and obligations on subsidiaries in s. 99 of the CE Act apply to the subsidiary.

[Refer CE Act, ss 52, 93, 96-102]

7.3 Key considerations

The parent Crown entity is accountable for the subsidiary's activities, including ensuring it complies with legislative restrictions. Among other things, the Board will want to put in place procedures for ensuring:

- best practice in the identification and appointment of directors for the subsidiary (including setting appointment terms and fees, see also the Fees section of this guidance in regard to fees for directors of subsidiaries)
- appropriate business planning and monitoring procedures, including that public accountability documents such as SOIs and annual reports for the parent adequately include information on the activities of the subsidiary
- an internal control environment is in place in the subsidiary so that it complies with statutory obligations and is well managed

- reporting to the parent entity's Board on the activities and the performance of the subsidiary, including any exceptions that are highlighted by the internal control environment.

8 Planning and reporting

Key Board responsibilities are strategic planning, monitoring and reporting publicly on the expected and actual performance of Health NZ: this enables Parliament and the public to hold Health NZ to account.

The CE Act sets out planning and reporting obligations of Health NZ, including the requirements for key accountability documents (see 8.1). The expectation that the Board is fully engaged in these areas is reflected by the requirement that these accountability documents are signed by members of the Board.

Communications between Ministers and Health NZ that inform the Board of its responsible Minister's expectations for the future direction of the entity are also an important part of the planning process.

So that the Board is aware of the planning and reporting requirements on an annual basis, a timetable is to be established and updated by the CEO. This timetable will include the documents being completed, the timeframe for their completion and the role the Board will play in their finalisation.

[Refer CE Act, Part 4]

8.1 Reporting and accountability documents under the Crown Entities Act

Health NZ is required to account to the House of Representatives for its performance through a suite of reporting and accountability documents, including:

- statements of intent (three-yearly and Minister may request at any time)
- a service performance agreement (which is treated the same as a statement of performance expectations for the purposes of the CE Act)
- annual financial statements
- annual reports.

These documents will be prepared under the leadership of the Board, signed off by the Board, and tabled in Parliament by the Minister.

[Refer CE Act, Part 4]

8.2 Reporting requirements under the Pae Ora Act

The Government Policy Statement on Health must include a framework for regular monitoring of progress and reporting requirements.

Health NZ and the Māori Health Authority are required to jointly prepare an annual performance report against the NZ Health Plan. The report must provide an assessment of the performance of both entities against outcomes specified in the Plan.

Health NZ and the Māori Health Authority must prepare an annual report assessing progress against the priority outcomes set out in the locality plan.

At least once every five years, the two entities must prepare a report on how the NZ Health Charter has been given effect throughout the health sector and include in the report any recommendations for changes to the charter.

[Refer Pae Ora Act ss 36, 52, 55, 58]

8.3 Minister's Letters of Expectations

Annual letter of expectations

The Minister's expectations for Health NZ's strategic direction and the Minister's specific priorities for the planning period may be reflected in a letter of expectation from the Minister to Health NZ. It may also cover expectations of Health NZ's governance and performance and of the monitoring of information to be provided. The letter will usually be sent annually to the Chair, before the Board starts its planning process.

Enduring letter of expectations

An enduring letter of expectations to Crown entities is issued periodically, with the most recent in October 2019: see Enduring-Letter-of-Expectations-to-statutory-Crown-entities-2019.pdf (publicservice.govt.nz). It sets out the ongoing expectations that the Minister of Finance and the Minister of State Services have of all statutory Crown entities. These expectations include ensuring workplaces are safe, diverse, and inclusive; supporting future-focused Māori-Crown relations; and contributing to improving current and future wellbeing. An enduring letter remains in force until it is replaced.

8.4 Statement of Intent (SOI)

The purpose of an SOI is to promote the public accountability of Health NZ (section 138, CE Act) by:

- enabling the Crown to participate in the process of setting the Crown entity's strategic intentions and medium-term undertakings
- setting out for the House of Representatives those intentions and undertakings
- providing a base against which the Crown entity's actual performance can later be assessed.

The 2013 amendments to the CE Act provide a stronger focus on strategic planning. The changes are:

- The SOI is solely about the strategic intentions of Health NZ.
- The content of an SOI must cover a minimum of four financial years.
- An SOI can last up to three years but should be regularly reviewed and updated where circumstances require. (The three-year period is measured from the date the SOI was provided to the Minister of Health.)
- The Minister of Health can ask for a new SOI at any time.
- Health NZ can provide a new SOI to the Minister of Health instead of providing an amendment to the final SOI.
- In certain circumstances, the Minister of Health can give Health NZ an extension of time for, or waive the requirement to provide, an SOI.
- Health NZ must publish the SOI (or any amendments) on its website once it is provided to the Minister of Health, unless the Minister has delayed publication during the pre-Budget period.

- There are various options for when and how an SOI is presented to the House after publishing. For example, Health NZ's SOI can be presented with the annual report from the previous year (giving Parliament both a backward- and forward-looking performance story) or with other documents.

Section 141 of the CE Act specifies what a SOI must contain. An SOI must set out the strategic objectives that Health NZ intends to achieve or contribute to (strategic intentions) and explain how Health NZ proposes to assess its performance.

Ministers may participate in determining the content of the SOI (section 145, CE Act) which includes: agreeing with Health NZ on any additional information to be incorporated; specifying the form in which any information must be presented; making comment on a draft SOI; and directing amendment in relation to some content of the SOI.

The SOI is prepared under the leadership of the Board; signed off by the Board; and tabled by the Minister of Health in Parliament. The SOI flows from Health NZ's strategic planning process and through it the Board expresses its strategic thinking and future intentions. The SOI articulates the impacts, outcomes or objectives Health NZ seeks to achieve or contribute to. It includes qualitative and quantitative (non-financial and financial) measures and standards against which future performance will be assessed.

The SOI will reflect engagement with the Minister of Health and the Ministry of Health through the planning process. It will also incorporate the Government's sector and all-of-government priorities.

8.5 Statement of Performance Expectations (SPE)

The purpose of an SPE is to:

- enable the Minister of Health to participate in setting the annual performance expectations of Health NZ
- enable Parliament to be informed of those expectations
- provide a base against which actual performance can be assessed.

Section 149E of the CE Act specifies the contents of an SPE. An SPE must include a concise explanation of what each reportable class of outputs is intended to achieve and explain how the performance of each reportable class of outputs will be assessed.

Ministers may participate in determining the content of the SPE (section 149H, CE Act) which includes agreeing with Health NZ on any additional information to be incorporated; specifying the form in which any information must be presented; making comment on a draft SPE; and directing amendment in relation to some content of the SPE.

8.6 Memorandum of understanding

A memorandum of understanding is not described in legislation but if used it is negotiated between the Minister and the Board. These vary but often they document the Minister's performance expectations of Health NZ; accountability arrangement such as the relationship with the Minister; and monitoring arrangements with the Ministry of Health.

8.7 Annual report

Health NZ reports on its performance to Parliament in its annual report (sections 150 - 157, CE Act). The annual report must include information to enable an informed assessment to be made of Health NZ's progress against its strategic intentions and its SPE.

Other information that must be included in an annual report is the annual financial statements for the entity, any direction given to the entity by a Minister in writing, and the total value of the remuneration paid to each member during the financial year (sections 151 and 152, CE Act).

The Annual Report must be in writing, be dated and be signed on behalf of the Board by two members (section 151(3), CE Act).

The Auditor-General is Health NZ's auditor but will generally appoint another auditor to act on their behalf. The auditor is required to audit the annual financial statements, statement of service performance, the annual report, and any other required or agreed information.

Health NZ must provide its annual report to the Minister of Health within 15 working days of receipt of the audit report: it is recommended that Health NZ provide a near final draft to the Ministry of Health to enable the Minister to be briefed on key issues.

9 Board Administration

9.1 Appointment and Term of Office

Appointment
The Minister appoints Board Members under the CE Act.

The Chairperson of the Māori Health Authority (or the nominated co-Chairperson referred to in section 22(3) of the Pae Ora Act) is, by virtue of holding that office, a member of the board of Health NZ with voting rights and may delegate that membership to a deputy chairperson of the Māori Health Authority.

[Refer CE Act, s 28; Pae Ora Act s 12, 22; PSC Guidance, Chapter 17, p 50; see also specific PSC Board Appointment and Induction Guidelines]

Term
Board Members are appointed for an initial term of up to three years. Board Members may be reappointed but are not entitled to automatic reappointment.

[Refer CE Act, ss 29-32, 44 and 45; PSC Guidance, Chapter 17, pp 51-54]

Appointment of Chair and Deputy Chair
The Minister is responsible for the appointment of the Chair and Deputy Chair (if required) of the Board, by written notice to the relevant Board Members (stating the date on which the appointment takes effect), with copies of the notice provided to the Board.

[Refer CE Act, Sch 5, clause 1]

Post-appointment induction
The Minister, the Board and Health NZ all have responsibilities in relation to induction of new Board Members. The PSC has developed a set of induction modules to assist those giving induction sessions.

The primary audience for the induction material is new Board Members but it may also be helpful for existing Board Members. These need to be shaped to the Board's situation. The PSC is happy to consider requests to assist with presentations in relation to "being a Board Member in the public service".

It is up to the Chair and Board to provide the detailed induction and background in relation to what their Board does and how the Board and Health NZ operate.

Reappointment principles
The Minister will decide whether a member should be reappointed when their term expires. Incumbent board members have no automatic right of reappointment and need to be aware that the requirements for appointment under the CE Act will apply.

[Refer CE Act, ss 29-32]

9.2 Termination of office

Removal from office
The Minister may, at any time and at their discretion, remove a Board Member from office.

[Refer CE Act, ss 36, 40, 41, 45, 58 and 59; PSC Guidance, Chapter 17, pp 53-54]

Resignation from office
A Board Member may resign by written and signed notice to the Minister (with a copy to Health NZ). The resignation is effective on receipt of the notice by the Minister, or at any later time specified in the notice.

[Refer CE Act, s 44. See also Schedule 5, clause 3 for resignation from Chair or Deputy Chair role; PSC Guidance, Chapter 17, p 52]

Disqualification from office
A Board Member is disqualified immediately from continuing in their Board Member role on certain grounds set out in section 30(2) of the CE Act, which include bankruptcy and being convicted of certain offences.

[Refer CE Act, ss 30 and 45; see also "PSC Board Appointment and Induction Guidelines" p 17]

No compensation on termination
A Board Member is not entitled to any compensation or any other payment or benefit relating to the ceasing of their Board Member role.

[Refer CE Act, s 43]

9.3 Board remuneration

The Minister sets Board Member remuneration under the Cabinet Fees Framework (Fees Framework). In [June/July 2022], the Cabinet Appointments and Honours Committee (APH) approved the Board's fees.

[Refer CE Act, ss 47 and 152; PSC Guidance, Chapter 18, pp 56-58; Fees Framework, Cabinet Office Circular CO (19), letter dated xxx from Minister of Health]

Board Fees
Board Member fees comprise an annual fee based on an assumed workload of [50 days] for the Chair and [30 days] for members. This covers all authorised work undertaken by Board Members, including reading and preparation time, involvement in Board meetings, and membership of Board Committees.

[Refer Fees Framework, para 39]

Committee Fees (External/Independent Committee Members)
External Committee Member remuneration is also set under the Fees Framework. In [Month] 2022, the APH approved for external Committee Members to be paid $xx per annum.

[Refer letter dated xxx from Minister of Health].

Expenses and Reimbursement
Board Members are reimbursed for actual and reasonable travelling and other expenses incurred in carrying out their office as Board Members, in accordance with the Fees Framework. See the Travel Policy and the Sensitive Expenditure Policy. [Refer to MoH policies until HNZ policies are ready]

Crown entities frequently receive requests from the public for information on expenses incurred. This information is generally provided under the Official Information Act 1982.

[Refer CE Act, s 48, Schedule 5, clause 15(1); Fees Framework, paras 92-94]

Reporting total remuneration
The total value of remuneration paid to each Board Member is disclosed in the annual report of Health NZ.

[Refer CE Act, s 152]

9.4 Chair and Deputy Chair

The Minister appoints the Chair, who is expected to be responsible for the following key matters:

- to chair Board meetings and ensure that thorough open and constructive debate, matters brought to the Board are decided so the Chief Executive can lead the execution of agreed policy
- to ensure that decisions are reached, and they are properly understood and recorded
- to represent the Board to the Minister
- to ensure the effectiveness and integrity of Board processes
- to manage conflict of interest issues as they arise
- to ensure that the Board's work programme is current and the Board meets its obligations in a timely fashion
- to conduct regular evaluations of the performance of the Board and its individual Members and to discuss these with each Board Member
- to meet regularly with the Chief Executive to ensure that critical matters are reviewed and if necessary incorporated into forward agendas for Board attention
- to represent the Board publicly
- to engage with the Minister in relation to Board Member appointments and reappointments.

The Minister also appoints the Deputy Chair, who is expected to act in the Chair's absence or incapacity or if there is no Chair. The Deputy Chair has, and may exercise, all the functions and powers of the Chair if the Chair is unavailable or is interested in a matter.

The Board may also appoint a Temporary Deputy Chair (by written resolution), who may exercise all the functions and powers of the Chair in relation to a matter if:

- there is no Deputy Chair
- the Deputy Chair is unavailable
- the Deputy Chair is interested in the matter.

A Temporary Deputy Chair is not entitled to any additional payment unless approved by the Minister. The Chair and Deputy Chair will notify the Board Secretariat and each other when they will be unavailable to perform their responsibilities.

[Refer CE Act, Sch 5, cl 1 and 5; PSC Guidance, Chapter 5, pp 18-19 and Chapter 17, pp 51-55]

Removal

The Minister may, after consultation with the person concerned, remove the Chair or Deputy Chair by written notice to the person (with a copy to the Board).

[Refer CE Act, Sch 5, cl 4]

Resignation

The Chair or Deputy Chair may, without resigning as a Board Member, resign from their role by written notice to the Minister (with a copy to the Board). The resignation notice must state when the resignation takes effect.

[Refer CE Act, Sch 5, cl 3]

9.5 Independent professional advice

Board Members may access independent professional advice on request at Health NZ's expense. Health NZ will meet the costs of independent advice obtained by a Board Member or Members if the following three criteria are met:

- the advice is necessary to enable the obligations imposed on the Board, a Board Committee or Member, through membership of the Board, to be properly fulfilled
- the Chair (or the Deputy Chair when the Chair is absent, or it is otherwise inappropriate to refer to the Chair) has approved the request being made
- the Chief Legal Officer, who will inform the Board Member(s) of the existence of relevant advice already in the hands of Health NZ, has been informed.

Generally external advice should be requested through the Chief Executive wherever possible as this assists in the identification and sharing of any existing advice as well as budget management.

9.6 Liability

Limited Immunity from Liability

Board Members are not liable for any Health NZ liability simply because they are Board Members.

If a Board Member acts in good faith and in the performance (or intended performance) of Health NZ's functions, that Board Member has no civil lability to any person. This immunity also applies to liability to Health NZ itself - unless there is also a breach of an individual duty (as detailed at 4.2).

This limitation of liability does not protect a Board Member's acts or omissions that are neither in good faith nor in the performance (or intended performance) of Health NZ's functions from criminal or civil consequences. Also, it only relates to civil liability and does not affect the right of any person to apply for judicial review.

Indemnity

Health NZ indemnifies Board Members for liability in respect of acts (or omissions) done in good faith and in the performance or intended performance of Health NZ's functions (including costs incurred in defending or settling any claim or proceeding relating to those acts).

Health NZ provides this indemnity under an indemnity deed entered into with each Board Member.

The form of indemnity deeds (and the provision of them to named Board Members, employees or non- employees (who may be appointed by Health NZ to external Boards)) are approved by the Board.

Insurance

Health NZ, through the Chief Financial Officer, has purchased Directors and Officers Liability insurance. This covers directors, senior executives and employees for their personal liability arising out of their duties as directors and officers and the reimbursement of Health NZ where it has indemnified its directors, including associated defence costs, subject to the terms and conditions of the policy. The policy cannot cover acts/omissions that are in bad faith or outside the performance (or intended performance) of Health NZ's functions. A copy of the insurance policy is available on request.

[Refer CE Act, ss 53-57 and 120-126; PSC Guidance, Chapter 19, pp 59-61]

SCHEDULE 1 – Health NZ Board Committees [TBC]

1) Capital and Infrastructure
2) Clinical Quality Assurance
3) Health and Safety

SCHEDULE 2 – Joint Board Sub-Committees [TBC]

1) Data and Digital
2) Finance and Audit
3) People, Culture, Development and Remuneration
4) Public Health Commissioning and Localities [name TBC]