INTRODUCTION

The Pae Ora Bill disestablishes the 20 DHBs and replaces them with Health NZ and establishes a Māori Health Authority (MHA) with Iwi-Māori Partnership Boards (IMPBs). The government has also announced the establishment of a new Ministry for Disabled people. These structural changes have been designed to improve the health outcomes for all New Zealanders, with a specific focus on some groups, Māori, Pacific, disabled and rural people, with the view to remove the significant variation in service availability, access, and quality between population groups.

DISABILITY

There will be a new ministry for Disabled People that will be stood up at the same time as Health NZ and the Māori Health Authority. All start on the 1 July 2022 and the Disability Strategy is due within 2 years after the commencement date. There is no reflection in this legislation of the interaction of the Minister of Health with the new Ministry for Disabled People. That is a major omission.

It is the Minister of Health's role to develop the Disability strategy (Part 2 10 (1) (a) (iv)), but there is a Disability Strategy that stays in place until the Minister for Disability Issues says it's no longer valid (Schedule 1, subpart 2, 6). Does the Minister of Health's Disability Strategy replace the Minister for Disability Issues Disability Strategy, or does it become a part of the new Ministry for Disabled People's Disability Strategy, presuming they will need to develop a strategy? The standing up of Health NZ, the Māori Health Authority and the new Ministry for Disabled People needs to be developed in conjunction, to understand the dynamics between the different entities and arrive at an effective solution that improves equality in health outcomes.

The disparity between Accident Compensation Corporation (ACC) funding of disability equipment and Ministry of Health funding of disability equipment has been signaled as a source of discontent within the current Health & Disability system. The Pae Ora Bill doesn't address any solutions to rectify this disparity.

INNOVATION

The Health System Principles in Section 7 (1) (d) (iv) of the Pae Ora bill state 'the health system should provide choice of quality services to Māori and other population groups by – harnessing clinical leadership, innovation, and technology to continuously improve services.'

Assistive technology leads to improving health outcomes on a range of levels:

- Assistive technology improves the ability to move/handle patients more comfortable and with less physical strain on the care provider.
- Assistive technology makes community living a possibility, keeping hospital beds free for other patients.
- Assistive technology improves the quality of life and lowers the long-term cost of care.
- Assistive technology increases societal outcomes that improves the long-term health outcomes for disabled people.
- Assistive technology allows people to fully contribute to their whanau and their community, work, and education.

Healthcare and technology are intrinsically intertwined: one doesn't exist without the other. Medical technology, including assistive technology, needs to have a strong feature in the government's plans to improve outcomes and create an equitable system.

Including the technology sector in an advisory role in the development of a Health Strategy, Disability Strategy, Māori Strategy, and a Pacific Strategy should be recognised in the legislation as a mechanism to improve health outcomes for all New Zealanders.

The market for assistive technology can be open, transparent, competitive, and commercially viable with a strategic focus on building a system that ensures access to the best technology available worldwide.

VALUE BASED HEALTHCARE & THE NZ HEALTH STRATEGY

The objectives of the NZ Health Strategy in section 37 of the Bill say that it must:

a) contain an assessment of the current state of health outcomes and health system performance; and
b) contain an assessment of the medium and long-term trends and risks that will impact on health outcomes and health system performance in the next 5 to 10 years; and
c) set out opportunities and priorities for improving the health system over at least the next 5 to 10 years, including workforce development.

Procurement in the New Zealand health market appears focused on reducing cost in the short term. The danger exposed by this approach it that costs are potentially higher in the long term. It's in the New Zealand population's interest to have access to the best value solutions that will eventually lead to better health outcomes for more New Zealanders.

Recognition of the benefits of technology should be clearly stated in this bill. Funding of assistive technology needs to appreciate the wider commercial benefits of rehab and getting people back contributing to society versus the actual cost of the equipment. Investment in modelling that measures all benefits/outcomes of healthcare solutions, including technology, will give insight into the best value investment in healthcare for New Zealanders.

Implementation of the Pae Ora legislation that does not encourage a change of direction in terms of procurement decision making towards value-based healthcare is a missed opportunity for truly improving health outcomes for all New Zealanders.

PHARMAC

The independent interim report released by the Minister of Health into pharmaceutical medicines buying agency Pharmac, has found issues relating to transparency of decision making, and fairness and equity of outcomes. This review only focuses on medicines, for the moment ignoring Pharmac's role in procurement of medical devices, albeit that this has been progressing over a few years now. The findings however are relevant to both medicines and medical devices. One of the pertinent finding states that there may be an excessive focus on containing costs - and a concern the cost-saving model may not be the right one to meet future health needs.

The role of Pharmac and where it sits in the restructured Health system needs reconsideration, in terms of their functions, their accountability and how they will contribute to meeting the strategic health goals for all New Zealanders and strategic health goals for identified subgroups: Māori, Pacific people and disabled people. The further removed procurement is from where the need is being

fulfilled, the more risk there is to achieving improved health outcomes, especially in areas where the health outcomes need to be boosted.

Comments on specific parts of the Pae Ora Legislation:

Part 1 – Preliminary Provisions

4 Interpretation

- ***pharmaceutical*** *(– means a medicine, therapeutic medical device, or related product or thing)* should probably be replaced with Therapeutics (- means treatments used to alleviate or prevent a particular disease. Examples of therapeutics include drug therapy, medical devices, nutrition therapy and stem-cell therapies.)
- ***public health means the health of—***
    - *(a) all the people of New Zealand;* ***or*** **(**it's unusual to define for the whole and then add sub groups)
    - *(b) a population group, community, or section of people within New Zealand*
- ***publicly available*** *– in relation to a document, means to publish it in a readily accessible format on an Internet site that—*
    - *(a) is administered by or on behalf of the Ministry or a health entity; and*
    - *(b) is publicly available as far as practicable and free of charge* (this caveat should be removed)
- ***services*** **–** this is a categorization of different types of services rather than an interpretation of what services are.

The interpretation for 'pharmaceutical' reflects the lack of focus on technology and how medical devices can improve the health outcomes for New Zealanders exponentially. The new structure proposed through this legislation will be ineffective unless the barriers to improved outcomes are recognized and addressed effectively. Currently opportunities to improve the outcomes may be being missed with a cost-based procurement strategy. It is imperative that this changes in the new Health Strategy for New Zealand, setting clear parameters and guidelines to the operation and accountability of Pharmac.

5 Guide to this Act

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

The Disability Strategy is one of the key health documents but there is no mention of the Ministry for Disabled People which is to be stood up by 1 July 2022. It seems to be left out of the legislation that should provide the overview of the health system and shows how insufficiently this legislation has been thought through on all its interdependencies of associated organizations or operations.

Pharmac provides a procurement service and as such needs to be clearly incorporated in the strategic health documents that are going to be prepared. Their key performance indicators need to be linked to the desired health outcomes for all New Zealanders and the monitoring of their performance by the Ministry of Health needs to be transparent in relation to these KPIs.

7 Health System principles

Māori seems to be the only specific group of interest under the Health System Principles. No mention of Disabled people or Pacific people as a specific group of interest. All three are identified as not receiving equality in health outcomes.

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

> *(1)(b) the health system should engage with Māori, other population groups, and other people to develop and deliver services and programmes that reflect their needs and aspirations, for example, by engaging with Māori to develop, deliver, and monitor services and programmes designed to raise hauora Māori outcomes:*
>
> *(1)(c) the health system should provide opportunities for Māori to exercise decision-making authority on matters of importance to Māori and for that purpose, have regard to both—*
>
> > *(i) the strength or nature of Māori interests in a matter; and*
> >
> > *(ii) the interests of other health consumers and the Crown in the matter:*

There should also be engagement with Māori, Pacific and Disabled within the decision making at Pharmac. The health system principles should be fully adopted within Pharmac. They are an integral part of the health system and have a significant impact on the health outcomes. In our view there is insufficient reflection of this in the draft legislation, which poses a risk to improving the health outcomes of New Zealanders. New Zealand runs the risk of siloed operations continuing and perpetuating the inefficiencies and inequalities perceived in the current system.

Part 2 Key roles and health documents

Subpart 1—Minister of Health

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

If it is legislated it should be done and if it's only a guide, why include in legislation?

Subpart 2—Health New Zealand

12 (3) is missing a criterium which applies for MHA board under 22 (2) (c).

> *<u>(c) cultural safety and responsiveness of services; and</u>*

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

> *(a) is, by virtue of holding that office, a member of the board of Health New Zealand with voting rights; and*
>
> *(b) may delegate that membership to a deputy chairperson of the Māori Health Authority.*

Why is the chairperson of the Health NZ Board not by virtue of holding that office, a member of the board of the Māori Health Authority? It would then seem that both boards have equal standing. Now it seems the board of the MHA is lower in the hierarchy.

Why is there a provision for co-chairs in the Māori Health Authority but not in Health New Zealand? What is the logic?

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

It's not defined here what this looks like, but it is defined for the Māori Health Authority under 21 (a) and (b).

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

What does this mean? How would this be possible? Surely the Health Strategy and the implementation of this should guide the decision making around the pharmaceutical schedule. Health NZ should oversee the efficacy of the pharmaceutical schedule.

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

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

We would expect this to be a requirement for the Māori Health Authority too, but it's not included in this bill.

16 Additional collective duties of board of Health New Zealand

> *(1) The board must ensure that Health New Zealand—*
>
> > *(a) acts in a manner consistent with the GPS and the New Zealand Health Plan; and*
> >
> > *(b) works collaboratively with the Māori Health Authority; and*

This is already under 14 Functions, so seems to be a repeat

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

Subpart 3—Māori Health Authority

> *19 (1)*
>
> *(b) own and operate services; and*

Would Health NZ monitor these services? If not, who would? All taxpayer funded owned and operated services should be accountable to a higher authority.

> *(n) design and deliver programmes for the purpose of improving the capability and capacity of Māori health providers and the Māori health workforce; and*

(n) is not mentioned as a function of Health NZ and likely should be.

> *3) The Māori Health Authority has all the powers necessary to perform its functions.*

What does this mean? It doesn't seem to be specified in the bill. This wasn't stated for Health NZ.

> *20 Engaging with and reporting to Māori*

Health NZ doesn't have the same requirements.

22 (4) ……except that the Minister must consult the Hauora Māori advisory committee before appointing any member.

The minister does not have to consult with any committee before appointing a Health New Zealand Board member.

23 Removal of members

There is nothing in the bill on **removal of** Health New Zealand **Board members**, only on removal of Māori Authority Board members.

Subpart 5—Key health documents

29 (1) (g) the Minister to determine a Code of Consumer Participation to support consumer participation and enable the consumer to be voice to heard.

This probably should read as "the consumer voice to be heard"

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

Including this statement removes the confidence that the minister may not perform the required duties. This isn't clear cut, indisputable legislation and should be removed.

This section appears to overlap with the Minister role in Subpart 1. If you remove "the minister to" and Health New Zealand and the Māori Health Authority, as they are also covered in their roles and function, it would be cleaner.

It then would read as:

This subpart requires—

(a) a Government Policy Statement that sets out the Government's priorities and objectives for the health system:

(b) the following strategies for improving the health status of New Zealanders:

(i) New Zealand Health Strategy:

(ii) Hauora Māori Strategy:

(iii) Pacific Health Strategy:

(iv) Disability Health Strategy:

(c) a New Zealand Health Plan based on population health needs:

(d) locality plans for localities:

(f) a New Zealand Health Charter to guide health entities and their workers:

(g) a Code of Consumer Participation to support consumer participation and enable the consumer voice to be heard.

: should likely be replaced with **;** in most cases in the list of key documents

Government Policy Statement on Health

> *(5) This Minister must issue the first GPS no later than 2 years after the commencement of this Act.*

2 years is a long time.

32 (1)

> *(c) the Government's priorities in relation to Māori, which must include the following priorities:*
>
> *(i) improving health outcomes for Māori; and*
>
> *(ii) engaging with Māori:*
>
> *(d) the Government's priorities for improving health outcomes for Pacific people, disabled people, rural communities, and other populations:*

32 (1) should also include - engaging with Pacific people, disabled people, rural communities, and other populations. These other groups seem to be less important, which is not socially acceptable.

> *(2) The GPS may include any other matters the Minister considers relevant.*

This sounds vague and begs the question why this is needed.

> *(3) To avoid doubt, the GPS may not impose an obligation on any health entity to approve or decline funding for a particular product, service, or provider.*

This doesn't sound like legislative language "to avoid doubt" and the meaning of this is unclear.

36 Amending GPS

> *(1) The Minister may amend the GPS at any time.*
>
> *(2) Sections 31 and 33 do not apply to an amendment to the GPS if the Minister considers the amendment is not significant.*

This gives the Minister the option to change legislation without any scrutiny, which is poor legislation and (2) shouldn't be included.

Health Strategies

> *38 (2) The purpose of the Hauora Māori Strategy is to provide a framework to guide the health system in improving Māori health outcomes.*

This could be expanded to equate 37 (2) i.e. protecting, promoting, and improving people's health and wellbeing. The same can be said for 39 (2) and 40 (2).

> 38 (3)

This is vaguer with medium to long term instead of adding in the 5-10 years as in 37 (3). If it makes sense to specify 5-10 years for New Zealand Health Strategy, it makes sense to do so for the three other strategies – Māori, Pacific and Disabled.

> *41 (1) (b) consult health entities or groups that the Minister considers are reasonably likely to be affected by the health strategy.*

As there will be a Ministry for Disabled People stood up by 1 July 2022, we would expect this entity to be specifically mentioned here. The connection between the two Ministries will need to be strategically coordinated and the provision for collaboration should be included in this legislation. The development of a new system appears to retain a similar disjointedness to the current system. As a result, barriers to improving health outcomes are less likely to be achieved.

45 (g) (2) will engage with Māori and protect Māori interests and aspirations; and

In recognition of the Disabled and Pacific people reflected in the key documentation we would expect that engagement with these groups be specified in the legislation as it is for Māori. Under 45 (g) the following could be added:

(3) will engage with Pacific people and protect Pacific people's interests and aspirations; and

(4) will engage with Disabled people and protect Disabled people's interests and aspirations.

47 (3) Subsection (1)(a) to (c) does not apply to any amendments to the plan that do not have a significant impact on consumers or providers of services (other than the boards of Health New Zealand and the Māori Health Authority)

Determining whether the amendment is significant is subjective. Therefore consultation should always happen, in advance of changes being made.

46 and 47 should be swapped around in order. It's a more logical order.

Localities and locality plans

49 (3) (iii) (iii) any other individual or group that Health New Zealand considers appropriate.

If Pacific people and Disabled people are identified as requiring a specific strategy, they should be identified as groups in this part of the bill too.

49 (4) No ministerial approval needed?

New Zealand Health Charter

52 (1) Here we are missing Disabled people and Pacific people again.

52 (2) The minister makes and approves the Charter – minister should make it and cabinet should approve it.

Part 3 Other roles

The number of board members varies between the different entities.

It is time to implement consistency.

Pharmac up to 6 members

Health New Zealand and Māori Health Authority 5-8 members

NZBOS up to 7 members

HQSC at least 7 members

78 Delegations policy

Health New Zealand and Māori Health Authority should also have a Delegations Policy.

79 Employees

Health New Zealand and Māori Health Authority should also have an Employees policy.

Subpart 5—Committees - Ministerial committees

There should be and advisory committee for disabled people.

Subpart 6—Iwi-Māori partnership boards

There could be a partnership board for disabled people.

Part 4 General

Subpart 1—Powers in relation to service commissioning

90 (7) only relates to Pharmac and NZBOS, and likely should also relate to HQSQ.

Schedule 1 - Transitional, savings, and related provisions

Part 1 - Provisions relating to this Act as enacted

Subpart 2—New Zealand disability strategy continued

This provision says the New Zealand Disability Strategy continues until the Minister for Disability Issues says so, but the Minister for Health is tasked to develop a Disability Strategy. There is no mention of the new ministry for Disabled People in this legislation and their role in developing a Disability Strategy, nor whether this encompasses health.

14 (3) Subclause (2) applies—

(a) unless the parties to the collective agreement otherwise; or

There seems to be a word missing.

21 (1) (b) is offered an alternative position as an employee in the Ministry that—

(a) has "is offered and accepts" – it's likely that is required in (b)

Schedule 2 - Consequential amendments to enactments

In some Acts DHB is replaced with Health New Zealand and Maori Health Authority in others it's just replaced with Health New Zealand.

ACC and Children's Act have both Health New Zealand and Maori Health Authority.

Biosecurity Act, Charitable Trusts Act, Victims' Rights Act have only Health New Zealand.

3E Public Health Agency

(9) To avoid doubt, the Director-General may revoke a designation of a person as a medical officer of health or health or protection officer under this section.

or health needs to be removed.