Document 1

MINISTRY OF HEALTH
MANATŪ HAUORA

# Briefing

## Update on the iGPS – iMHA board feedback and headline measures to achieve priorities

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| **Date due to MO:** | 28 January 2022 | **Action required by:** | 11 February 2022 |
| **Security level:** | IN CONFIDENCE | **Health Report number:** | HR 20212754<br>DPMC2021/22-1263 |
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Cc:** | Hon Peeni Henare, Associate Minister of Health | | |

## Contact for telephone discussion

| Name | Position | Telephone |
|---|---|---|
| Maree Roberts | Deputy Director-General, System Strategy & Policy, Ministry of Health | s 9(2)(a) |
| Stephen McKernan | Director, Health Transition Unit | s 9(2)(a) |

## Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

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# Update on the iGPS – iMHA board feedback and headline measures to achieve priorities

| | | | |
|---|---|---|---|
| **Security level:** | IN CONFIDENCE | **Date:** | 28 January 2022 |
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Cc:** | Hon Peeni Henare, Associate Minister of Health | | |

## Purpose of report

1. This report provides you with an update on the development of the interim Government Policy Statement (iGPS) to test your comfort with the direction of new content, and your agreement to progress to our next stage of engagement with the interim health boards.
2. It outlines:
   a. the current status of the draft iGPS and how we have incorporated the feedback you provided to us in December 2021 [HR20212373 refers];
   b. the feedback from our engagement with the interim Māori Health Authority (iMHA) board in December 2021 and January 2022, and how we have addressed this;
   c. new content for inclusion in the iGPS, including a new Te Tiriti chapter, and high-level 'headline measures' that can be used to track progress on achieving iGPS priorities;
   d. our proposed approach for the next stage of engagement with the interim health boards.
3. Annexed to this report are the key areas of the iGPS that have been updated as a result of your and iMHA feedback, and related proposed headline measures.
4. This report discloses all relevant information and implications.

## Summary


5. We provided a first draft of the iGPS on 26 November 2021, seeking agreement on the priorities for inclusion as outlined in the draft [HR20212373 refers]. You were broadly comfortable with the direction of the document and provided some detailed comments in December 2021. These have been incorporated into the version of iGPS attached as Annex One, with your key changes highlighted.
6. You agreed that early engagement on the iGPS with the iMHA board, ahead of engagement with the interim Health New Zealand (iHNZ) board, was appropriate due to their anticipated strategic role and responsibility for driving improvements in hauora Māori across the system [HR 20212373 refers].
7. We shared the high-level priorities from the November draft with the iMHA board in December 2021 and had further engagement with them in January 2022. A key aspect of their feedback was the importance of having a stronger focus on Te Tiriti and a transformation


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approach at the centre of the document, to match the aspirations of the health reform. This feedback has been incorporated in Annex One.

8. You also signalled the importance of detailing the specific measures that will be used to determine success against the priorities outlined. We have provided proposed headline measures, and their reasons for inclusion in the draft iGPS in Annex One. A chapter explaining how these measures relate to the wider accountability work programme and the development of an outcomes framework is being drafted as part of the joint TU-Ministry workstream.

9. Subject to your feedback, the next stage of work is to refine the iGPS further by developing the strategic narrative to ensure that it is focused on the key priorities and changes expected. We propose to engage with the iMHA and iHNZ on the priorities and their sequencing, so that the iGPS is clear about what is most important and provides a strong strategic direction for the emerging interim NZ Health Plan. It is important that the entities have a sense of ownership of the priorities and measures.

10. We propose sharing the content in Annex One with the iMHA and iHNZ boards in early February, after receiving your further feedback. We expect that this will commence an iterative process of development over the period of February-March, which will lead to further proposed amendments.

11. We will provide separate advice on the proposed approach to targeted sector stakeholder engagement on the iGPS [HR 20212157 refers] in the coming weeks.

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## Recommendations

We recommend you:

a) **Note** that we have incorporated your feedback on the draft interim Government Policy Statement (iGPS) in the current iteration of the document attached as Annex One.

b) **Note** that we have engaged with the interim Māori Health Authority (iMHA) board twice since December 2021 and have received their feedback on the high-level hauora Māori priorities in the draft iGPS.

c) **Note** that we have incorporated the iMHA board feedback in the document at Annex One.

d) **Note** that we have incorporated initial proposed measures to determine success against the agreed priorities in the document at Annex One; and that precise metrics will be subject to further work and agreement.

e) **Agree** to provide feedback on the next iteration of the iGPS attached at Annex One, particularly focusing on the proposed headline measures of success. **Yes**

f) **Agree** to our proposed engagement with the interim health agency boards in February 2022 using the material at Annex One. **Yes**

g) **Note** that we will provide separate advice on undertaking targeted engagement with sector stakeholders on the iGPS in the coming weeks, and that this advice will include an updated version of the iGPS which incorporates any further feedback.

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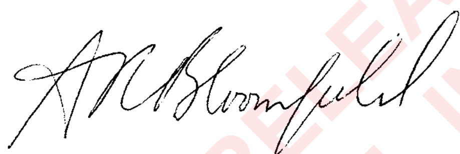

Dr Ashley Bloomfield
**Director-General of Health**
Date: 28/01/2022

Simon Medcalf
**Health Lead, Transition Unit**
Date: 28/01/2022

Hon Andrew Little
**Minister of Health**
Date:

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# Update on the iGPS – iMHA board feedback and headline measures to achieve priorities

## Background

1. On 26 November 2021 we provided advice on the overall approach to setting priorities through the iGPS, and a first draft of the document [HR 20212373 refers]. On 6 December 2021, you provided written feedback on this draft.

2. As agreed, high-level priorities from this draft were used to inform engagement with the iMHA board due to their anticipated strategic role in hauora Māori as set out in the Pae Ora Bill [HR 20212373 refers]. This engagement intended to provide them with your initial priorities for inclusion and to seek their input on the approach. We have met with iMHA twice across December 2021 and January 2022 to discuss their feedback.

3. We have produced a further iteration of the priorities and expectations in the iGPS, incorporating your feedback and iMHA feedback. This also includes initial proposed high-level measures to be used to determine success against the agreed priorities outlined in the iGPS. Both these are discussed further below and the current draft is attached as Annex One.

4. The next critical step is to engage formally with the boards of both interim agencies, to set out the emerging Government priorities to inform their planning parameters and assumptions for the preparation of initial operating budgets and the interim NZ Health Plan. This advice seeks your agreement to do so in early February.

5. We would welcome the opportunity to discuss the iGPS and the advice in this paper at our officials meeting with you on Tuesday 1 February.

### Status of the draft iGPS

6. As noted, the current draft incorporates your early feedback and that of the iMHA Board, and has been revised to begin to focus on the key expectations within each of the priority areas.

7. In aggregate, our view is that the current draft would benefit from further prioritisation and contains too many individual expectations to provide a clear, focused direction which is aligned to the reform narrative. Further indication of sequencing of priorities will also support delivery through the interim NZ Health Plan, and tackle the risk that the expectations collectively appear overwhelming.

8. Our expectation is that the final GPS will provide a compelling story for the first two years of the reformed system, and a clear set of priorities for action. At a high-level, these should include priorities for:

   a. maintaining system performance and delivering the COVID-19 response – to ensure continued delivery of health services through change and minimise risks of disruption, with a focus on key metrics and deliverables;

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continuing system transformation to demonstrate the benefits of reform– through early initiatives, actions and new investments which show the opportunities of the new system model, such as in tackling inequity and postcode lottery in access, reducing duplication and rolling out new models of care; and

b. embedding the new relationships and processes that will drive change in the new system – with an emphasis on te Tiriti o Waitangi, the foundational relationship between Health NZ and the Māori Health Authority and critical actions to implement the new model, working towards full operation from July 2024.

c.

9. All of the above are contained within the current iGPS, but getting the story and presentation right will be crucial. There are elements of this prioritisation that we intend to take forward in coming weeks, including reviewing the requirements of existing system strategies and considering which should be targeted in the next two years, as noted below. However, in general we believe that the next stage of focusing the iGPS content would be best taken forward in collaboration with the interim agencies, to promote their ownership of the priorities and provide clear strategic direction for the interim Health Plan.

10. The attached draft document does not repeat the narrative opening and closing chapters which you reviewed in the previous iteration. Rather, it focuses on the chapters which will present the Government's expectations and key deliverables. This is intended to focus your feedback at this time on the material that we intend to share with the boards of the interim agencies. Further work will be undertaken on the broader narrative for the iGPS in the coming weeks.

## Responses to your feedback on the November draft iGPS

### Summary of feedback

11. Your feedback provided on the November draft iGPS highlighted the need to reference the accountability framework at the outset of the document to strengthen the foundations for setting expectations in the iGPS. You also noted that these performance expectations – as driven by the accountability framework – need to be reinforced throughout the document.

12. You asked to see a version of the iGPS that includes outcomes and measures of success that are more quantifiable.

13. In specific priority areas, you asked for the following areas to be emphasised:

a. In priority 1 on laying the foundations for the system, the importance of the establishment of strong, productive relationships between the new entities and the Ministry of Health, as well as the wider government to meet the health needs of communities.

b. In priority 4 on developing the workforce culture, the importance of developing a positive, high-performance workplace culture and environment so that work is rewarding and satisfying.

### How we have addressed your feedback

14. To address your comments on setting out the accountability framework at the outset, we propose the addition of a new section within the strategic context section titled *"the*

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*interim Government Policy Statement and accountability in the future health system"*. The purpose of this section will be to provide context to the document and to situate the iGPS within the broader accountability framework and reformed health system. We propose using graphics to illustrate this with explanatory text to make it clear and easy to digest.

15. This chapter is being drafted alongside work on the accountability framework as part of the joint TU-Ministry workstream. Specific references to this framework – for example the monitoring and indicators frameworks or business rules – will be made throughout the document, particularly as some elements of the accountability framework will be annexed to the iGPS itself.

16. To address your comments in specific priority areas (see paragraph 8 above), we have added text to reflect your feedback and will ensure these areas are emphasised as the iGPS is further developed.

17. To address your comments on the need for more quantifiable outcomes, see the section below on how we propose to measure success from the iGPS.

## Responses to iMHA board feedback on the November draft iGPS

### Summary of feedback

18. In our engagement with the iMHA board, a key piece of feedback was that the iGPS is a crucial component needed to achieve the five key system shifts of the reform. Moreover, the iGPS also needs to be centred on a more transformational and aspirational approach to reflect this.

19. Alongside this, their feedback was that a Te Tiriti approach must be at the centre of the document, with the following specific feedback on some ways to achieve this:
    a. That Te Tiriti needs to be the baseline equity and focus of the iGPS, with other equities stemming from this. They emphasised that this was particularly important to support the sector in understanding equity as a factor in health outcomes.
    b. That, as the iGPS sits above the New Zealand Health Plan, it needs to include Te Tiriti performance measures and Wai 2575 principles; to establish a clear hierarchy.
    c. That we need to ensure that we are using consistent wording around Te Tiriti principles and framing to ensure there is a common understanding of expectations in this area.

20. The iMHA, in line with your feedback, also provided feedback that the iGPS's position within the accountability framework needs to be clearer.

21. The board also acknowledged that their approach is distinct from that of iHNZ, as they are focused on transformational reform in the first two years, while iHNZ is focused on consolidation and stability as well as reform.

### How we have addressed their feedback

22. We support the board's feedback regarding centring Te Tiriti in the document, and have added a standalone chapter at the beginning which sets expectations in how Te Tiriti principles must be honoured in the reformed health system. This also includes specific headline measures for how this can be achieved, drawn from Whakamaua. It highlights

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principles such as tino rangatiratanga, equity, active protection and partnership, and the ways in which they should be embedded.

23. This new opening priority is intended as a complement to, rather than a substitute for, actions which reinforce Tiriti obligations and principles in the other priority areas. The iGPS as a whole should embed Te Tiriti and we expect this to be evident in all chapters. We will continue to discuss how to detail the ways in which these principles are embedded throughout the subsequent chapters in our engagement with iMHA.

24. We also note the board's views on the balance between stability, consolidation and transformation. This is a balance which the iGPS as a whole must seek to strike in order to be ambitious yet deliverable. We will continue to work in coming weeks on refining the narrative of the iGPS to reflect these issues and ensure attainable actions in the first two years.

25. We will also work to ensure consistent wording throughout the document on in relation to Te Tiriti and concepts such as hauora Māori and mātauranga Māori being particularly mindful as we draft the narrative.

## How we will measure success in the iGPS

26. As well as setting out expectations and priorities, the iGPS also needs to set out specific measures of success relating to the identified priorities for the reformed system in the next two years. The purpose of these measures will be to support accountability for delivery of the iGPS and reinforce system and entity-level monitoring over the period.

27. The types of measures to be captured in the iGPS are likely to vary based on the priority area or action to which they relate. In some cases, there will be a clear quantitative metric (or a reasonable proxy) that is closely linked to the objective. In other cases, there may be relevant qualitative measures, including for delivery of particular milestones (e.g. production of a plan). The iGPS will need to strike a balance between providing quantifiable measures of success and setting achievable expectations.

28. The measures in the iGPS will not be the only sources of information to support monitoring of the health system. There will be a wider set of metrics and measures that are relevant to health system monitoring but do not track directly to expectations in the iGPS. These will include some population health measures, for instance healthy life expectancy, which are contextual and may signal medium and longer-term outcomes, but which are not well suited for supporting accountability in a two-year period. We expect that this wider set of metrics will form a system-level outcomes framework, and will provide you with further advice on this in the coming weeks.

29. We have provided proposed headline measures to determine success against the agreed priorities in the document at Annex One. These are based on Ministerial and Cabinet reform priorities and the five key system shifts and draw on the existing health system indicators where relevant. We intend to iterate these and confirm precise metrics where possible, in order to arrive at a core set of indicators for each chapter which will underpin accountability for delivery of the expectations.

30. Precise metrics for the measures will be subject to further work and agreement. A chapter explaining how these measures relate to the wider accountability stream and the development of an outcomes framework is being drafted as part of the joint TU-Ministry workstream.

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31. We propose that these indicative headline measures are used to start the engagement with the interim health boards on how best to measure success in the first two years. In this engagement, we will also work with them to sequence the priority actions (i.e. those in the left-hand column in Annex One) in recognition of the challenge in progressing all these actions at the same time. Undertaking this work in collaboration with the interim agencies should support a productive working relationship from the beginning.

32. In addition to specific metrics, there will be a further decision as to whether to attach any specific performance expectations in the iGPS. This might involve a quantified marker of expected performance (i.e., a target), or could indicate the expected trend, whether directional (i.e., upwards or downwards) or in relation to closing disparities (e.g. reducing the gaps between population groups).

33. In some cases, you may wish to signal a clear performance expectation to drive planning assumptions for the interim NZ Health Plan, recognising the potential impacts. We will provide you with further advice on performance expectations following initial engagement with the boards of the interim entities.

34. If you are comfortable with the headline measures, we will develop them into evaluative statements around what success looks like in our engagement with the interim boards. We will test these with you in the next iteration of the iGPS alongside our advice for targeted stakeholder consultation.

35. We will then work with the interim health boards to develop specific metrics that will sit underneath each of these evaluative statements and will provide you with these in the coming months. These will be developed alongside the wider accountability workstream.

## Further work to be undertaken

36. In addition to the refinement and prioritisation of the iGPS with the interim agencies, there are several related workstreams underway that will provide further detail to the iGPS and shape the final product:

a. Identifying the key priority actions for the two-year period from the existing strategies and programmes which are referenced in the draft iGPS. This will be undertaken jointly by the MoH and the TU.

b. Identifying key measures of success for the cross-agency strategies supporting a range of outcomes. This will be undertaken with support from relevant agencies.

c. Further development of a detailed system-level outcomes framework, which is being undertaken as part of the joint MoH-TU accountability workstream.

d. Review of detailed common business and technical rules for the health system (previously the Operational Policy Framework) for inclusion in the iGPS, subject to your agreement.

e. Review of the national minimum service expectations which set a common baseline for service availability and access (previously the Service Coverage Document), in line with your steers on the future public offer and changes for agreed new Budget initiatives. This is also to be included in the iGPS subject to your agreement.

f. Development of communication to the interim agencies on the anticipated range of funding expected following Budget 2022, to inform their early work on internal budgets and assumptions for the interim NZ Health Plan and statements of

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performance expectations. This communication will be aligned with discussions on the iGPS as far as possible to present a clear steer on planning parameters.

37. The outputs from these workstreams will be consolidated and a narrative will be developed in late March/April into a near-final iGPS for your review and agreement, pending final Budget decisions.

## Next stages of engagement on the iGPS

38. Pending your feedback on the updated version of the iGPS, we will continue engagement with iMHA and commence engagement with iHNZ on the content attached as Annex One and on further developing the headline measures. We propose that this engagement will take place from early-February and will be an ongoing process as the iGPS is further developed.

39. As noted above, this process of engagement with the interim agencies will help to test the emerging iGPS and indicate areas for refinement and consolidation. It will also support alignment with the interim Health Plan, and incorporate and align advice from a funding signal to the entities following the Health Budget bilateral meeting, if agreed by joint Ministers, to present a clear set of planning parameters. We anticipate an iterative process over the coming weeks and will advise you of proposed changes in our next advice.

40. We are also working on the proposed approach to consultation on the iGPS with sector stakeholders. Our preliminary advice to you has tested your comfort levels in keeping this consultation targeted, due to the extensive engagement undertaken for the review [HR 20212157 refers]. We will provide formal advice on this in the coming weeks.

41. We will also continue to engage with key stakeholders – e.g. other agencies - as needed on the subsequent iterations of the iGPS.

## Next steps

42. We look forward to discussing your feedback on the current iteration of the iGPS and proposed approach for board consultation at our next officials meeting, in particular the headline measures of success that have been developed.

43. As above, you will receive advice on the proposed targeted consultation with sector stakeholders in the coming weeks. This advice will include an updated version of the iGPS which incorporates any further feedback and will seek agreement for the targeted sector stakeholder engagement.

44. The Ministry and the TU will continue to work closely, particularly focusing on the dependencies and interrelation with the accountability workstream.

**ENDS.**

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## Annex One: Draft content from the interim Government Policy Statement to be shared with interim agencies

*See attachment.*

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Document 2

# Briefing

## Update on the iGPS – feedback from interim entities and approach to sector engagement

| | | | |
|---|---|---|---|
| **Date due to MO:** | 16 March 2022 | **Action required by:** | 22 March 2022 |
| **Security level:** | IN CONFIDENCE | **Health Report number:** | HR 20220248 |
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Copy to:** | Hon Peeni Henare, Associate Minister of Health | | |

## Contact for telephone discussion

| Name | Position | Telephone |
|---|---|---|
| **Ashley Bloomfield** | Director-General of Health | s 9(2)(a) |
| **Stephen McKernan** | Director, Health Transition Unit | s 9(2)(a) |

## Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

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Document 2

# Update on the iGPS – feedback from interim entities and approach to sector engagement

| **Security level:** | IN CONFIDENCE | **Date:** | 16 March 2022 |
|---|---|---|---|
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Copy to:** | Hon Peeni Henare, Associate Minister of Health | | |

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## Purpose of report

1. This report provides you with an update on the development of the interim Government Policy Statement (iGPS) and seeks your agreement to our proposed approach to stakeholder engagement.
2. It outlines:
    a. the high-level feedback we received from our engagement with the interim Māori Health Authority (iMHA) and interim Health New Zealand (iHNZ) on the emerging content on the iGPS as you agreed on 4 Feb [HR 20212754 refers], and how we propose to incorporate this into the next iteration
    b. proposed changes based on further engagement with subject matter experts and further analysis of key health strategies
    c. an integrated approach to stakeholder engagement on the iGPS within the context of progress with the reforms, and other priority topics.
3. This report discloses all relevant information and implications.

## Summary


4. In January 2022 we provided you with a high-level draft of the iGPS which incorporated your feedback on the initial version, as well as feedback from the iMHA board [HR 20212754]. Following your agreement, this was then shared with both interim boards before we met with them in early February. A copy of the material shared with the boards is attached (Annex 1).
5. We have since received additional feedback from the iMHA board, and from senior officials within iMHA and iHNZ. This feedback includes suggestions to further embed Te Tiriti o Waitangi throughout the iGPS, to align the level of each priority and objective, increase clarity about the levers to monitor and achieve equity, and ensure the narrative puts people at the centre of the future health system.
6. Further engagement with subject matter experts in the Ministry, Transition Unit and Treasury has resulted in additional proposed changes to emerging iGPS

content in relation to the implementation of existing health system strategies and action plans; increased focus on priority groups, population and public health; and more focus on the value and benefits of spending in the context of financial sustainability.

7. We are working to incorporate the feedback, and further feedback expected from the iHNZ board, in the next iteration due to you on 31 March 2022. We expect these to include some changes to the chapter focus and content of the iGPS, as well as how the information is presented. This iteration will include the core content of the iGPS in narrative form, which addresses the feedback received to date within the context of the priorities we have discussed with you over the past several months.[1]

8. We have developed a proposed approach for sector stakeholder engagement, based around you and your colleagues' involvement and with support from the Director-General of Health and inter-agency Chief Executives.

9. We propose an integrated approach that allows the iGPS to be positioned in the wider reform developments such as the New Zealand Health Plan and Health Charter. The approach provides an opportunity to both canvas the iGPS content and its intended role, as well as discuss progress with the reforms, and other priority topics.

10. This approach will allow for a wide range of stakeholders to be involved in online sessions and will be supplemented with a small number of targeted meetings led by officials with key stakeholders as required.

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[1] HR 20212157; HR 20212373; and HR 20212754 refers.

Document 2

## Recommendations

We recommend you:

a) **Note** that with your agreement we circulated draft material on the interim Government Policy Statement (iGPS) to the interim Māori Health Authority (iMHA) and interim Health New Zealand (iHNZ) boards, and met with both boards and their senior officials.

b) **Note** that we have received feedback from senior officials within iMHA and iHNZ, and from the board of iMHA, and further feedback from subject matter experts in the Ministry, the Transition Unit and Treasury

c) **Note** that we expect to propose changes to the areas of focus in the chapters of the iGPS and the specific content of priorities in light of this feedback.

d) **Indicate** if you are broadly comfortable with our proposed approach to addressing the feedback received as described in this briefing. **Yes** / **No**

e) **Note** that we will incorporate the feedback we have received and any feedback you may have in the next version of the iGPS due to you on 31 March 2022.

f) **Note** the proposed engagement approach on the iGPS balances meaningful engagement with stakeholder capacity and considers the wide engagement already undertaken on the reforms.

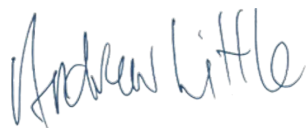
f) **Note** the proposal that the iGPS engagement is part of an integrated engagement plan that will update stakeholders on progress with the reforms, and other priority topics.

g) **Agree** that we will provide further detail on an integrated engagement plan for April – June 2021 on the reforms, that the iGPS engagement will sit within, by 31 March 2022.

h) **Forward** to Minister Sio and Minister Verrall, subject to your comfort with the proposed stakeholder approach. **Yes** / **No**

pp:
Dr Ashley Bloomfield
**Director-General of Health**
Date: 16/03/2022

pp:
Stephen McKernan
**Health Lead (Director), Transition Unit**
Date:16/03/2022



Hon Andrew Little
**Minister of Health**
Date: 20/3/22

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# Update on the iGPS – feedback from interim entities and approach to sector engagement

## Context

1. We have provided you with two high-level drafts of the iGPS: the first in November 2021 [HR 20212373 refers], and the second in January 2022 which incorporated initial feedback from you and the iMHA board [HR 20212754 refers].

2. Following your agreement on 4 February 2022, we formally shared the draft iGPS to both interim health boards on 4 February 2021. To assist with our discussion of the draft priorities and their sequencing, the material shared was focused on high-level priorities and did not include the strategic context material which will frame the document. A copy of the material shared with the boards is attached (Annex 1).

3. Through workshops and written feedback, we have subsequently received input from the iMHA board and senior officials within iMHA. IMHA officials noted their general support for the current content in the iGPS, along with their desire to work with us to incorporate their feedback in the next iteration of the iGPS due to you on 31 March 2022.

4. We have received feedback and held workshops with senior officials from iHNZ. We also received initial feedback from the iHNZ board, which we understand will be followed by more comprehensive feedback. We expect this to occur in time to reflect it in the next iteration of the iGPS.

5. We also committed to providing you with advice on an approach to targeted consultation for sector stakeholders [HR 20212157 refers]. At the officials meeting with you on 28 February 2022 we discussed how best to proceed with this engagement. You indicated that you and your Associate Ministers would like to be involved, which we have incorporated in the proposed approach below.

## Feedback from interim entities and proposed changes to emerging iGPS content

### Feedback received from the interim Maori Health Authority

6. The key feedback from iMHA was:

   a. Priorities outlined in 'Priority 1: Embedding Te Tiriti o Waitangi' need to be further integrated and made consistent throughout the iGPS.

   b. More specificity is required for how entities and the wider system are to meet Te Tiriti obligations.

   c. Māori health aspirations need to be framed positively, with 'what matters to people and whānau' at the centre.

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   d. Need to further outline the approach to and understanding of key concepts and expectations, such as what it means to embed mātauranga Māori throughout the system, and how the system supports an approach to Māori data sovereignty.

7. We propose to address this feedback by:

   a. Māori health teams across the Ministry, Transition Unit and iMHA are currently working together to ensure 'Priority 1: Embedding Te Tiriti o Waitangi' reflects the approach and direction set out in Whakamaua: Māori Health Action Plan 2020-25. This will support consistent framing across the iGPS and address specific expectations around meeting Te Tiriti obligations throughout each priority.

   b. In subsequent versions of the iGPS, explaining in more detail why particular measures were chosen. While the initial monitoring framework for Day One will use a blend of existing system and reform programme measures to track progress priorities within the iGPS, over the first two years of reform the Ministry will develop a longer-term, outcome-based framework to support the full GPS and full NZHP from July 2024 [HR 20220355 refers]. This will build on the framework already set in Whakamaua, which was developed following considerable engagement with Māori.

   c. Ensuring the iGPS sets strong obligations and expectations for Te Tiriti and hauora Māori, without being overly prescriptive as to how entities are to fulfil them. Discussions are underway between officials in the Māori Health Directorate and iMHA to achieve this balance, including through ensuring cohesion between iGPS and the interim NZ Health Plan.

   d. To assist with engagement and discussion of priorities, the core content of the iGPS has remained in short form to date. The next version will position the priorities within a wider narrative about the people that these actions, expectations and measures are ultimately about. This will achieve a balance between setting an aspirational vision with people's health and wellbeing at the centre, while also setting priorities and expectations for the health system to achieve it.

### Feedback received from interim Health New Zealand

8. The key feedback from iHNZ to date is:

   a. A clearer articulation of how the system both embeds Te Tiriti and ensures accountability for equity for all priority groups.

   b. Current measures and actions are not at a consistent level of specificity and aspiration.

   c. The critical role that people, whānau and communities have in improving system performance and shaping its design needs to be reinforced.

   d. Specific mention of other priorities should feature, such as tackling unwarranted variation, clinical excellence and health infrastructure.

9. The iHNZ board has also provided some detailed feedback on the workforce section. This feedback will be worked through, alongside further iHNZ board feedback for the next iteration.

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10. We propose to address this feedback by:

    a. The next iteration will more clearly frame the discussion of obligations to Māori arising from Te Tiriti o Waitangi as well as measuring and addressing equity for all population groups, to avoid conflating the two. The levers and accountabilities for improving equity across populations will be further emphasised and aligned with existing strategies.

    b. The current set of expectations and measures intend to both set the early foundations for reform and provide ambitious direction for the future system. Upcoming refinements will seek to improve this balance, including the language used to articulate the level of expectation.

    c. Reinforcing the role that people and whānau voice play in improving and shaping the system can be achieved by framing proactive engagement through consumer voice mechanisms, Iwi-Māori Partnership Boards, and localities as key inputs to improving system performance, alongside quantitative data, monitoring insights and evidence.

## Other proposed changes to emerging iGPS content

11. As well as engaging with representatives from iMHA and iHNZ, we have continued to engage with subject matter experts within the Ministry (including the interim Public Health Agency), Transition Unit, and Treasury. Key feedback, and our proposed approach to incorporating it in the next version of the iGPS, includes:

    a. **Reframing how entities will implement existing health system strategies and action plans.** In response, we are working with stakeholders to identify and align the key priorities and levers within documents such as Whakamaua, Ola Manuia and the Disability Action Plan, and articulate how they best sit within the health system architecture and accountability framework. Specific actions within these strategies may be better referenced in the interim NZ Health Plan, which sets more tangible actions for entities to achieve the direction set in the iGPS.

    b. **Increased visibility of priority population groups and the focus on population and public health.** In response, discussion on these reform priorities will be strengthened, in line with the role that population and public health play in the reforms. References to health services will be broadened to include wider health intervention and prevention measures that support wider determinants of health.

    c. **In the context of financial sustainability, more focus is required on the value and benefits of spending rather than cost and financial indicators.** While expectations for fiscal responsibility within a fixed budget are required, focusing on the value investments generate is central to achieving reform ambitions. We are working with key stakeholders to more clearly reflect this in the next draft, and to include more explicit consideration of giving effect to Te Tiriti o Waitangi in financial sustainability settings. It has also been suggested that the financial sustainability priority be widened to include environmental sustainability: we are exploring how this might be done without diluting the priority.

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# Proposed approach to targeted stakeholder engagement

## Overview of approach and stakeholders

12. The following approach balances the importance of meaningful engagement with stakeholder capacity and the impact of the COVID-19 Omicron outbreak on the sector, and considers the wide engagement already undertaken on the reforms.

13. There is an opportunity for an integrated set of engagements between April and June 2022 led by you and with support from Associate Ministers and the senior leadership from the Ministry, Transition Unit, iHNZ and iMHA. This will provide a platform to engage with stakeholders in the role of the iGPS and the priorities it sets, within the context of an update on reform progress and other 'building blocks' such as the Health Charter and NZ Health Plan. This would be designed to align with other planned or ongoing engagement on the reforms and wider priorities.

14. We propose three to four engagement sessions from April to June, using an online format to enable wide participation. We will disseminate information on these sessions to relevant stakeholders allowing them to choose which, if any, they attend.

15. Each session will provide an overview of the reform work to date and what the next few months will look like, covering aspects such as the expectations for Day 1 and the development of the Health Charter and NZ Health Plan. The sessions will explain the iGPS in this context, explaining how it fits in with the rest of the reformed system, its intended purpose and the key government priorities and measures contained within it. Each will also provide a significant slot for Q&As and will be pre-recorded to share for those unable to join the event.

16. In addition to the core content across the three to four sessions, proposed themes for each session may include how the reforms, including the key components such as the iGPS, are addressing the following:
    a. Embedding Te Tiriti o Waitangi into the health system;
    b. Improving equity in the health system;
    c. Strengthening population and public health;
    d. Improving primary and community care; and
    e. Improving hospital and specialist services.

## Ministerial and agencies' involvement in engagement

17. We propose that you attend all of the sessions in some capacity – i.e. for the whole session or for parts of it to allow you to update the sector on the reform progress, speak about your priorities for the reformed health system and demonstrate the importance and roles of the iGPS, Health Charter and NZ Health Plan. We also propose the Associate Ministers attend the sessions related to their portfolio interest and capacity to do so.

18. Subject to your feedback and depending on you and your colleagues' availability, we will work with your office on how best to undertake this proposal and provide

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further detail by 31 March. If it is not feasible for you to participate in live events, we can explore how pre-recorded message might be incorporated into online sessions.

19. The Director-General of Health and inter-agency Chief Executives will be available to support the online sessions, for example by covering relevant parts of the reform and assisting in answering audience questions at the end of each session.

### Risks and mitigations

20. We note the current Covid-19 situation will have significant impact on stakeholders' interest and ability to feedback on the iGPS and reforms generally. Therefore, the proposed engagement approach reduces some of the risks traditional engagement activities (e.g. hui, kōrero, etc.) might pose to staff and stakeholders. The approach provides transparency and a time-efficient way for organisations and individuals, including those in rural areas, to comment or feedback on the Government's strategic priorities.

21. Further, having the engagement relating to the wider reforms, and positioning the iGPS within this, allows for stakeholders to both receive an update on the wider reform programme and understand more about the iGPS.

    There is a risk that some stakeholders may feel that this is not genuine engagement because the reform is well under way and the broad priorities for the iGPS have already been established, and / or because a draft iGPS document is not being provided for stakeholder feedback. We will address these risks through the framing of the engagement and proactive and reactive messaging highlighting the connections between draft iGPS priorities, previous consultation, and wider reform activities.

## Te Tiriti o Waitangi obligations and equity

22. The proposed changes to the emerging iGPS content are focused on designing and implementing a system that delivers equity for priority populations, including Māori, Pacific people, people with disabilities, and the rainbow and ethnic people's communities. Amendments proposed will also outline expectations for Te Tiriti o Waitangi obligations and principles to be embedded within and by entities.

23. For the stakeholder engagement, a Te Tiriti and equity lens will underpin this work. This will mean ensuring that our work processes (i.e. the engagement approach) and products (i.e. comms material), both meet our obligations as Tiriti partners and support equitable outcomes.

24. This will include considering embedding any Tiriti obligations and equity considerations that are raised into the iGPS and ensuring that issues and concerns raised that are outside the scope of the iGPS are communicated to and followed up by other aspects of the health reform programme.

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## Next steps

25. Following your comment on our proposed response to feedback on the draft iGPS, we will provide you with a narrative version of core iGPS content on 31 March 2022.

26. We will provide further detail on the wider reform engagement, that we propose the iGPS fits within, in the next update on 31 March 2022.

27. We will continue to engage with the interim Health NZ, interim Māori Health Authority and across other agencies to seek views on the emerging content of the iGPS and make appropriate links to wider Government policy objectives. These additional insights will inform the drafting of the next version of the iGPS.

28. We will separately discuss your expectations for service coverage and service performance expectations, which will inform the technical appendices of the iGPS.

29. We will also be seeking your agreement to monitoring priorities for the first two years, including expectations for how existing risks will be managed, at the next Joint Ministers meeting. You will receive a separate briefing on this to support this discussion.

**ENDS.**

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# Annex 1 - Emerging content for the Interim Government Policy Statement on Health 2022-24

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## Priority 1: Embedding Te Tiriti o Waitangi [new chapter]

| **Overview** | **Proposed headline measures and rationale** | **Comment** |
|---|---|---|
| *The Government expects that the reformed health system will reorient itself to meet the principles and obligations of Te Tiriti o Waitangi at all levels. For this to become a reality, this reorientation must include changes in how health services are designed and delivered, with a focus on achieving equity of health outcomes for Māori, and how the system is managed and governed, with partnership and clear decision-making roles for Māori. The following section outlines expectations for the system in effecting key Te Tiriti principles.* | **Proposed measures**<br>• The health system is addressing racism and discrimination in all its forms [metric to be agreed]<br>• Funding received by kaupapa Māori health service providers to increase<br>• The percentage of Māori reporting unmet need for primary health care decreases<br>• The percentage of Māori in the regulated workforce and in leadership roles<br><br>**Why it matters** | |
| **Priorities during the first two years of the reform** | | |
| **Tino rangatiratanga**<br>• Entities must ensure meaningful leadership for hauora Māori in all system entities and levels, with diverse workforce leaders and expertise in mātauranga Māori in management and governance.<br>• Identify and provide opportunities for Māori to lead areas of decision-making in the health system, including in the development and agreement of priorities and service plans for hauora Māori.<br>• Entities must continue to work with each other, MoH and wider government on the action point in Whakamaua to design and implement a Māori data sovereignty approach for the health and disability system in partnership with Māori | | |

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| **Equity**<br>• Entities must act in accordance with the following four objectives of Whakamaua and continue to deliver on the actions set out.<br>o Accelerate and spread the delivery of kaupapa Māori and whanau centred services<br>o Shift cultural and social norms<br>o Reduce health inequities and health loss for Māori<br>o Strengthen system accountability settings<br>• Ensure a zero-tolerance approach to bias, racism and discrimination in all its forms across the health system.<br>**Active protection**<br>• Develop and implement a multi-year service plan for hauora Māori that focuses on reducing inequities in priority health outcomes<br>**Options**<br>• Expand kaupapa Māori services and approaches to support additional people to receive care.<br>• Embed commissioning principles and practices that reflect and comply with the principles of Te Tiriti | • Te Tiriti principles and obligations inform innovation and changes in ways of working from the outset | |
| **Partnership**<br>• Embed genuine partnership with Māori in decision-making, priorities and monitoring of outcomes at all system levels.<br>• Support iwi-Māori partnership boards to develop capacity and infrastructure to input the perspectives of iwi, hapū and whānau into local priorities and plans. | | |

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## Priority 2: Laying the foundations for the future system

<table>
<tr><th>Overview</th><th>Proposed headline measures and rationale</th><th>Comment</th></tr>
<tr><td>As the new entities progress from becoming operational on 1 July 2022 to becoming fully developed by 30 June 2024, the first two years of the reformed health system will be critical to establishing and refining new structures, roles and relationships, and beginning to embed a new culture and ethos founded on Te Tiriti principles. The accountability framework is vital, with the ultimate objective of achieving better health performance through better access (right time, right place) and better outcomes.<br><br>The actions and expectations in this section are the crucial steps to embed the new system.<br><br>These include specific expectations for new and existing entities, including their roles and responsibilities; how they will work together; and how they will engage with, respond to, and meet the health needs of whānau and communities, Pacific, and disabled populations. It also includes expectations on how entities will work with the Ministry of Health and the wider government to achieve these outcomes.</td><td rowspan="3">Proposed measures<br>• Health entities are working effectively together to achieve iGPS priorities [metric to be agreed]<br>• Improved use of resources (people, IT, and infrastructure) and delivery mechanisms support continued service provision [metric to be agreed]<br>• Safe transfer of staff and assets to the new health entities [metric to be agreed]<br>• Rollout of Hira programme [metric to be agreed]<br><br>Why it matters</td><td rowspan="3"></td></tr>
<tr><td>Priorities during the first two years of the reform</td></tr>
<tr><td>Implement the reformed system model, roles and relationships<br>• Ensure the safe transfer of staff, assets and liabilities to different entities, and the ongoing support and management of staff. This includes confirming conditions of employment.<br>• Review and refine the initial operating model of new entities to continuously improve the exercise of functions.<br>• Roll out new commissioning, co-commissioning and service delivery arrangements, including the detailed design and implementation of locality provider networks, and hospital networks.</td></tr>
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|---|---|---|
| • Develop the first NZ Health Plan as a fully costed plan for service delivery from 2024-2027. | • Collective effort is needed for the success of the iGPS and the interim NZ Health Plan<br>• Services remain stable throughout the reform changes whilst innovative improvements help to maximise what we have now and leverage both regional and local ways of working | |
| **Establish a one-system culture and ethos**<br>• Strengthen relationships, processes and ways of working between all system entities to ensure a shared focus on improving equity and health outcomes for New Zealanders.<br>• Align and share subject matter expertise at senior leadership level and throughout the entities, including for hauora Māori; Pacific health; disability; mental health and addiction; research, science and evidence.<br>• Develop strong, productive relationships with Ministry of Health, and the wider government. This will support the establishment of cross-sectoral mechanisms that are needed to tackle the social determinants of health.<br>• Embed a culture of evidence-based decision-making (from governance to policy to delivery), that uses multiple frames of evidence, especially mātauranga Māori.<br>• Promote organisational values that support wellbeing and healthy workplace culture and performance excellence.<br>• Ensure zero-tolerance of bias, racism and discrimination in all its forms across the health system.<br>• Ensure adherence to the common business rules and processes set out in Annex [1] – the reviewed operational policy framework [subject to review, to follow]. | | |

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| Embed community feedback to drive system performance<br>• Establish appropriate expertise, mechanisms and information flows to ensure the feedback of Māori, Pacific people, people with lived experience, whānau and populations with specific cultures and needs drives prioritisation and performance at all levels of the system.<br>• Support the transition of existing consumer, community and whānau partnerships, including Consumer Councils, into the reformed system model.<br>• Embed the Code of Consumer Participation in all parts of the system. | | |
|---|---|---|
| **Ensure integration of infrastructure, including data and digital**<br>• Ensure science, evidence, intelligence, analytics and innovation are embedded across the new health system, with capability from the outset.<br>• Continue development of Hira, the national health information platform, which will support accessible and actionable data and information to digitally enable service shifts and innovation across the health sector.<br>• Develop data and digital as a strategic function across entities to share and embed analytical insights across the system and with community partners, and to drive system performance. | | |

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# Priority 3: Keeping people well and independent at home

<table>
<tr><th>Strategic overview</th><th>Proposed headline measures and rationale</th><th>Comment</th></tr>
<tr><td>One of Government's critical system shifts intended through these reforms is to increase access to a wider range of health services provided in the home and in communities, to help people and whānau remain healthy and independent and prevent health needs where possible. This will improve equity by targeting resources, using population health approaches, and delivering services that are whānau-centred, and focus on Māori, Pacific and disabled people.</td><td rowspan="3">Proposed measures<ul><li>Improved access to mental health and addiction services [metric to be agreed]</li><li>Improved integration between primary and secondary care [metric to be agreed]</li><li>Rate of hospital admissions for (i) children under 5 and (ii) people aged 45–64 for an illness that might have been prevented or better managed in the community</li><li>Proportion of the NZ population covered by a locality</li><li>Tamariki and rangatahi experience improved health outcomes [metric to be agreed]</li><li>Tamariki and rangatahi have improved access to health</li></ul></td><td rowspan="3"></td></tr>
<tr><td>Priorities during the first two years of the reform</td></tr>
<tr><td>Improve equitable access to population, primary and community health services designed around the needs of people<ul><li>Increase funding for primary and community health services as a proportion of total health spending, with year-on-year increases greater than the overall growth in Vote Health.</li><li>Roll out community-based service models which shift services out of hospitals, with a focus on improving access for Māori, Pacific and other groups with the poorest health outcomes, and avoiding unnecessary visits to hospital.</li><li>Complete the national rollout of the Budget 2019 programme to expand access and choice of new community mental health and addiction services, including kaupapa Māori, Pacific and youth-specific services.</li><li>Embed Te Tiriti-compliant commissioning principles and practices and invest in whānau-centred services.</li><li>Support Māori health sector capability and capacity to innovate and deliver effective services for Māori communities and ensure that Māori health development is increasingly led by iwi and hapū.</li></ul></td></tr>
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| • Support Pacific health sector capability and capacity to innovate and deliver effective services for Pacific communities and whānau.<br>**Embed an evidence-informed population health approach**<br>• Foster and embed partnerships across health sector entities, with the wider social sector and with providers working with whānau and communities, to develop a shared focus on the health and wellbeing of the population at all levels.<br>• Develop and deliver tailored population health-based service models to whānau and communities, in line with their needs and aspirations.<br>• Ensure that planning and design for services take into account population health inequities and the wider determinants of health and wellbeing.<br>• Support individuals, whānau and communities to have a range of information, tools, resources and support to manage their own health and wellbeing.<br>**Build the foundation and infrastructure for care in the locality approach**<br>• Implement 6-10 locality prototypes to test, refine, and evaluate the locality approach and harness learning to accelerate roll out across New Zealand.<br>• Expand the locality approach to cover at least 50% of the NZ population by June 2024. In these localities:<br>o Establish the first phase comprehensive primary care teams and priority cohorts in localities to support the implementation of integrated provider networks, including across community, secondary and specialist services, as well as including broader social services and supports.<br>o Ensure that there is alignment between the localities and the iwi-Māori partnership boards to provide Māori voice into localities.<br>• Develop the implementation plan, as part of the full NZ Health Plan, to ensure the completion of full rollout of the locality approach to all areas of NZ by June 2026, including actions to ensure readiness of providers to formalise networks. | services (including mental health) [metric to be agreed]<br>**Why it matters**<br>• Government priorities for health outcomes are delivered on, including any new or existing priorities to improve services or that transition across to the new entity settings | |

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## Priority 4: Achieving equity in system performance

<table>
<tr><th>Overview</th><th>Proposed headline measures and rationale</th><th>Comment</th></tr>
<tr><td>Improving the quality of hospital and specialist health services, and equitable access to those services when they are needed, is one of the key system shifts of the reforms. These reforms provide an opportunity, moreover, to strengthen mechanisms across the system to support iterative improvement and track progress for all services. This includes how the system uses evidence, shares information and engages with people and whānau.<br><br>This section sets out key priorities for delivery in the next two years that will realise the benefits of existing programmes and ensure continuous improvement across the system.</td><td rowspan="3">Proposed measures<br>• Stabilise performance of health services through response to COVID-19 [metric to be agreed]<br>• Improved access and experience related to health services for Māori, Pacific and disabled people [metrics to be agreed]<br>• Variation in access to services, and health outcomes between Māori and non- Māori decreases [metrics to be agreed]<br>• Improve access to planned care [e.g. People who had surgery or care that was planned in advance, as a percentage of the agreed number of events in the NZHP]</td><td rowspan="3"></td></tr>
<tr><td>Priorities during the first two years of the reform</td></tr>
<tr><td>Implement existing priority programmes to realise the benefits for all New Zealanders<br>• Whakamaua:<br>    • Act in accordance with objectives<br>    • Continue actions to ensure meeting Te Tiriti obligations, achieving equity for Māori and enhancing kaupapa approaches through all levels and levers<br>    • Continue to address findings in WAI 2575<br>• Kia Manawanui:<br>    • Continue building an integrated continuum of mental wellbeing supports<br>    • Strengthen mental health and addiction leadership capability at all levels of the health system and across sectors.<br>• Ola Manuia:</td></tr>
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| ◦ Continue actions to enable health and wider services to better support Pacific peoples to thrive.<br>• Disability Action Plan:<br>◦ Improve access to, quality of and accessibility of health services, communications and products for disabled people and their whānau<br>◦ Gather insights, and data to enhance services and monitor health outcomes for disabled people.<br>• Child and Youth Wellbeing Strategy.<br>• Implement the Maternity Action Plan, address findings from the Well Child Tamariki Ora review, and progressing the Early Years programme. | • Reduce unplanned hospital utilisation [e.g. Number of days spent in hospital for unplanned care including emergencies]<br><br>**Why it matters**<br>• Reducing variation in health-related services to improve access, quality of service, experience, and outcomes for all New Zealanders, particularly Māori | |
| **Ensure continued service delivery and improvement throughout the COVID-19 pandemic**<br>• Ensure the delivery in all areas of the minimum national service requirements set out in Annex [2] – the revised service coverage schedule [subject to review, to follow]<br>• Implement Health System Preparedness activity, including more coordinated regional ways of working and models of care to ensure consistency in delivery and reduce wait times<br>• Strengthen connections between primary and hospital-related services to ensure equitable access to care which includes better decisions on location of some services.<br>• Incorporate insights from the response into the wider system and pandemic preparedness plans. | | |
| **Establish a whole-system approach to continuously improving the quality of health services**<br>• Establish baseline metrics for system performance and quantifiable goals for improvement, in line with priorities in the iGPS and the requirements of the system-level monitoring framework. | | |

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| • Ensure leading benchmarks are embedded across the system to monitor performance variation.<br>• Develop and embed evidence-based improvement methodologies to respond appropriately to poor or declining quality.<br>• Ensure measures, evaluative methods and reporting processes include an equity focus, particularly for Māori, Pacific and disabled people.<br>• Implement and share local and international research across the health, social and academic sectors, and promote the involvement of people, whānau and clinicians in research activities.<br>• Develop clinical research capacity more equitably across regions to feed up local priorities, support relationships with academics and clinicians, and include and protect mātauranga Māori, Pacific insights, and knowledge throughout the system. | | |
| **Improve access and quality of hospital and specialist health services**<br>• Maintain and improve access to planned care while ensuring delivery of the COVID-19 response, with an overall reduction in the waiting list for elective surgery compared to June 2022.<br>• Assess the variation in availability and waiting times for planned care between regions and population groups and identify early areas for improvement in the first two years through the interim NZ Health Plan.<br>• Accelerate time between diagnosis and first treatment for cancer, with a specific focus on equity between groups. | | |
| **Deliver a national approach to improve the flow and use of health information for people and communities**<br>• Ensure access to information and the ability to conduct and create insights for all organisations in the health system.<br>• Enable people and their whānau to access more of their health information to better navigate the system and be active participants and to lead their health journey. | | |

| | | |
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| • Ensure that health data and insights are used to monitor progress and inform action on equity for Māori, Pacific and disabled peoples.<br>• Increase the scope of, and accessibility to, patient-reported metrics including patient-reported outcomes.<br>• Develop data and digital as a strategic function across entities to share and embed analytical insights across the system and with community partners, and to drive system performance. | | |

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## Priority 5: Developing the workforce of the future

| **Strategic overview of section** | **Proposed headline measures and rationale** | **Comment** |
|---|---|---|
| *The health workforce is the most important factor in achieving genuine change, including achieving equity and addressing racism and discrimination in all its forms. Over the next two years our priority is cultivating a high-performance environment where the health workforce is proactively managed, enables equity, is fairer, more unified and that health is career of choice. This will be achieved by taking a whole of system, whole of workforce approach underpinned by data to ensure we have the right people in the right place at the right time. The future workforce will be competent, teams based, flexible, better reflect the community it serves, particularly for Māori and Pacific, and embed the principles of Te Tiriti o Waitangi at its core.*<br><br>*To support health as a career of choice, there needs to be a focus on developing positive, high-performance workplace cultures and environments so that work is rewarding and satisfying. This section sets expectations for actions.* | **Proposed measures**<br>• Overall workforce turnover/retention rate, split by job category<br>• Health and care workforce engagement and satisfaction increases [metric to be agreed]<br>• Delivery of a national workforce plan<br>• Health workforce gaps are progressively minimised, with a focus on priority groups [metrics to be agreed]<br><br>**Why it matters**<br>• Planning for future workforce needs will be critical to improve capacity, capability and cultural shifts that are needed to support system change | |
| **Priorities during the first two years of the reform** | | |
| **Establish a system-wide plan for the development of the health workforce**<br>• Develop and deliver a national workforce plan by June 2024 (to sit under a national workforce strategy) that:<br>a. identifies high risk health workforce professions that require prioritisation and intervention;<br>b. defines the skills and competencies that are required to deliver new models of care (including for kaiāwhina workforces);<br>c. agrees what data is required to be collected to understand the workforce fully (both by profession and by skills and competencies) and develop the infrastructure to accurately collect this data; | | |

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<table>
<tr><td>d. considers the diverse range of workforces across the health system, including clinical and other enabling roles in commissioning, management, digital and research;<br>e. presents a pathway to address supply and demand issues systematically for key professions.</td><td></td><td></td></tr>
<tr><td>Tackle skills and capacity gaps to reduce pressures on the current workforce<br>• Undertake steps to tackle immediate workforce issues, including a focus on priority workforces such as COVID-19 and mental health and addiction.<br>• Value and retain the health workforce (and avoid unnecessary attrition):<br>o Support the wellbeing of the workforce and creating pathways for people to work flexibly and to the full range of their scopes of practice, while supporting new and emerging workforces.<br>o Develop consistent approaches to continuing professional development and enabling research and innovation.<br>o Support the workforce to be change ready, agile, and responsive, including to changes in technology and the need for digital literacy.<br>o Create a map to achieve safe staffing by 2024.</td><td></td><td></td></tr>
<tr><td>Embed the principles of Te Tiriti o Waitangi in workforce development<br>• Develop a representative workforce where underrepresented communities are visible and widely represented, particularly in clinical and leadership roles.<br>• Support the development of Māori and Pacific health workforces that reflects Māori and Pacific values and models of practice and care.<br>• Ensure all health workforces have the skills, abilities and cultural safety expertise to provide an effective service to diverse communities, particularly those communities that have been under-served by the health system, in particular Māori and Pacific people.<br>• Support the workforce to respond to their obligations within the Health and Disability Code, including the provision of reasonable accommodations for disabled people.</td><td></td><td></td></tr>
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| • Support the Health Charter and wider system changes that focus on increased cultural safety throughout the system. | | |
|---|---|---|
| **Foster a common ethos and shared values**<br>• Foster and embed a positive culture through leadership and minimise disruption through the transition.<br>• Provide leadership and stewardship for the entire workforce, including a clear of vision of the future state.<br>• Embed use of the NZ Health Charter to guide the values, principles, and behaviours for the health workforce.<br>• Embed flexible by default guidance by SSC / PSC guidance.<br>• Move towards nationally consistent approaches for workforce development and training by 2024, including across sectors where relevant. | | |
| **Promote health as a career of choice**<br>• Develop a nationally consistent model for workforce training and placements and create a national infrastructure for training and placements that starts with rangatahi in high school through to health professionals employed in the sector.<br>• Embed a system of innovation in education and training approaches and deliver on innovative initiatives – starting with the iNZHP initiatives.<br>• Develop more flexible staircasing pathways for training and education which encourages workforce retention within the health sector. | | |

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Document 2A

## Priority 6: Ensuring a financially sustainable system

<table>
<tr><th>Overview</th><th>Proposed headline measures and rationale</th><th>Comment</th></tr>
<tr><td>The health system must live within its means to ensure that it provides both the best value for money to New Zealanders now, and that the system is sustainable for future generations. This requires actions to manage demand for health services, and to ensure that funding is targeted at addressing inequity and areas of greatest need. It also necessitates a focus on improving productivity and managing assets effectively.<br><br>This section will also set out the confirmed multi-year funding envelope for the health system (following Budget 22) including any high-level breakdown of appropriations.</td><td rowspan="4">Proposed measures<br>• Track towards surplus/deficit at financial year end<br>• Variance between planned budget and actual spending<br>• Delivering productivity and efficiency improvements [metrics to be agreed]<br>• Investment decisions are prioritised towards achieving equity and value for patients and the system [metric to be agreed]<br>• Investment decisions are aligned to evidence of impact on equity, effectiveness and value for money [metrics to be agreed]</td><td rowspan="4"></td></tr>
<tr><td>Priorities during the first two years of the reform</td></tr>
<tr><td>Ensure that the system will “live within its means”<br>• Develop the systems, reporting structures, and accountabilities to enable all parts of the sector to run in a financially sustainable manner.<br>• Ensure a shift toward integrated planning, strong operational and cost management, robust asset management planning, and a long-term approach to remediating key deficits in the system.<br>• Ensure that the system will not need additional public funding outside of a major, external and unforeseeable disruption to the underlying structure of health requirements (e.g. a pandemic, earthquake etc.), or extremely large, unpredictable or unplanned shocks to economic input costs (e.g. large surges in inflation affecting multiple sectors that are not driven exclusively by wage settlements).</td></tr>
<tr><td>Identify and harness efficiency and productivity gains<br>• The reforms are designed to improve value for money by increasing productivity, reducing duplication and supporting ways of working that improve efficiency, including by reducing unwarranted variation in practice, and promote a “one-</td></tr>
</table>

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| | | |
|---|---|---|
| system ethos"; put in place systems to track these anticipated efficiency and productivity gains, including those arising from new initiatives, models of care, and the consolidation of DHB functions and programmes. | **Why it matters**<br>• Financial sustainability is maintained into the longer term so that the system effectively manages funding so that:<br>  • Funding is targeted to maximise services for NZ to meet need<br>  • Re-baseline of the system is effective | |
| **Implement new funding and financing arrangements to support equity, value for money and quality**<br>• Review and revise how funding is allocated within HNZ and MHA, to promote equity and support greater provision of, access to, and accessibility of community care, and home and community support services.<br>• Support and incentivise integration through funding arrangements and mechanisms:<br>  o across localities, and between hospital and specialist services on the one hand and primary and community services on the other, and<br>  o between the health system and other sectors.<br>• Create the basis for "choosing wisely" within available resources and, eventually, creating productivity gains.<br>• Benchmark data routinely on the effectiveness, cost-effectiveness and affordability of interventions, and put in place the arrangements to better achieving allocative efficiencies across the system, and to identify and determine new ways of providing services and improving outcomes.<br>• Ensure that financial arrangements are appropriate to both publicly provided services and those provided or financed outside the public sector, since these play a significant role in the system and their affordability plays an important role in access to care. | | |

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Document 2A

| Continue the development of robust capital settings and management<br>• Integrate service and capital planning, from the commencement of projects and including data and digital investment proposals.<br>• Continue and accelerate ongoing improvements in asset management underway in the Health Infrastructure Unit.<br>• Build the system's capacity and capability to deliver major capital projects. | | |
|---|---|---|

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Document 3

MINISTRY OF HEALTH
MANATŪ HAUORA

# Briefing

## Update on the iGPS – draft narrative and detailed plan for engagement in April-June 2022

| **Date due to MO:** | 7 April 2022 | **Action required by:** | 14 April 2022 |
|---|---|---|---|
| **Security level:** | IN CONFIDENCE | **Health Report number:** | HR 20220424 |
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Copy to:** | Hon Peeni Henare, Associate Minister of Health | | |

## Contact for telephone discussion

| Name | Position | Telephone |
|---|---|---|
| **Dr Ashley Bloomfield** | Director-General of Health | s 9(2)(a) |
| **Stephen McKernan** | Director, Health Transition Unit | s 9(2)(a) |

## Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

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# Update on the iGPS – draft narrative and detailed plan for engagement in April-June 2022

| | | | |
|---|---|---|---|
| **Security level:** | IN CONFIDENCE | **Date:** | 7 April 2022 |
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Copy to:** | Hon Peeni Henare, Associate Minister of Health | | |

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## Purpose of report

1. This report provides you with an update on the development of the interim Government Policy Statement (iGPS). It seeks:
    a. to test your broad comfort with the direction of the first draft narrative iGPS attached in Annex 1
    b. your agreement to share the draft iGPS with the board of the interim Māori Health Authority (iMHA) and, subject to their feedback and any necessary changes, the interim Health NZ (iHNZ)
    c. your agreement to the plan for stakeholder engagement during April - June 2022 set out in Annex 2.
2. This report discloses all relevant information and implications.

## Summary


3. On 16 March 2022 we provided you with an update on the iGPS that included high-level feedback from senior officials within iMHA and iHNZ, the board of iMHA, and subject matter experts in the Ministry, Transition Unit and Treasury. On 20 March 2022 you indicated that you were broadly comfortable with our proposed approach to addressing the feedback received.
4. The first draft narrative version of the iGPS (the draft iGPS) attached in Annex 1 seeks to articulate the key priorities and provide a high-level description of how they will be monitored. It retains the six priorities from the previous version with some relatively minor wording refinements. It reflects initial feedback from iMHA officials.
5. We have sought to avoid excessive, prescriptive detail of 'how' health entities will go about delivering on the priorities. Some detail from the previous version has been removed; however, in areas where you have highlighted specific expectations to date, we have retained more prescriptive expectations. We will provide advice on any other areas that may appropriately include prescriptive actions in the next version of the iGPS, following your approval of the service

performance expectations for the new entities and the Day 1 monitoring framework, both of which you will receive a separate briefing on in April.

6. We wish to test your comfort with the form and content of the draft iGPS and seek your agreement for us to share this narrative version with the iMHA board. Following any necessary changes, we will also share the draft iGPS with iHNZ. We will work with the interim NZ Health Plan team to ensure the priorities and expectations in the iGPS are reflected in the plan.

7. We will continue to refine the draft iGPS to reflect upcoming advice on monitoring arrangements and Budget 22 decisions. This will include the key messages from the April 2022 Letter of Expectations that will provide new entities with clarity for their planning intentions (you will receive this in the separate briefing on service performance expectations in April).

8. A detailed plan for stakeholder engagement is attached in Annex 2. This proposes four online engagement events to be held from late April to the end of June 2022 for your agreement. We are working with your office to block out time in your diary for these events.

## Recommendations

We recommend you:

a) **Note** that further feedback from the interim Māori Health Authority (iMHA) and initial feedback from the interim Health NZ (iHNZ) has now been incorporated into a first draft narrative version of the interim Government Policy Statement (the draft iGPS) attached in Annex 1.

b) **Note** that the draft iGPS will continue to be refined following further feedback from interim health entities; advice to you in April on entity and system monitoring arrangements for day 1 and the first two years of the reformed system; Budget 22 decisions; and design, proofreading and consistency edits.

s 9(2)(g)(i)

c) **Indicate** if you are broadly comfortable with the direction of emerging structure and content in the first draft narrative version of the iGPS.

d) **Agree** that the Ministry can share the draft iGPS in Annex 1 with the board of the interim Māori Health Authority (iMHA) and, subject to their feedback and any necessary changes, officials and the board of the interim Health NZ (iHNZ) for further feedback.

e) **Note** we will ensure the priorities and expectations in the draft iGPS and your April 2022 Letter of Expectations are reflected in the interim New Zealand Health Plan (iNZHP).

f) **Note** that we will incorporate additional interim health entity feedback and come back to you with a further draft iGPS for review in early May.

g) **Agree** to the engagement plan in Annex 2 so that the Ministry can proceed with detailed planning for stakeholder engagement beginning in late April.

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s 9(2)(g)(i)

h) **Forward** this briefing to Minister Sio and Minister Verrall, subject to your comfort with the engagement plan.

Dr Ashley Bloomfield
**Director-General of Health**
Date:

Stephen McKernan
**Health Lead (Director), Transition Unit**
Date:

Hon Andrew Little
**Minister of Health**
Date: 10/4/22

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# Update on the iGPS – draft narrative and detailed plan for engagement in April-June 2022

## Context

1. On 16 March 2022 we provided you with a briefing updating you on the iGPS that included high-level feedback from senior officials and the board of the interim Māori Health Authority (iMHA), initial feedback from the interim Health NZ (iHNZ), and subject matter experts in the Ministry, the Transition Unit and Treasury [HR 20220248 refers].

2. The feedback included suggestions to:

    a. further embed Te Tiriti o Waitangi throughout the iGPS

    b. align the level of each priority and objective

    c. increase clarity about the levers to monitor and achieve equity

    d. ensure the narrative puts people at the centre of the future health system

    e. reframe content in relation to the implementation of existing health system strategies and action plans

    f. increased focus on priority groups, population, and public health

    g. add more focus on the value and benefits of spending in the context of financial sustainability.

3. We noted that the next iteration would provide the core content of the iGPS in narrative form, and we expected it to include some changes to the chapter focus and content, as well as how the information is presented. On 20 March 2022 you indicated that you were broadly comfortable with our proposed approach to addressing the feedback received.

## First draft version of the iGPS

### The draft iGPS summarises key priorities and how they will be monitored

4. The first draft narrative version of the iGPS (the draft iGPS) is attached in Annex 1. This version revises the material we provided to you on 16 March 2022, addressing the feedback received to date within the context of the priorities we have discussed with you over the past several months. The draft iGPS presents the longer-term outcomes for the health system as well as time-bound expectations. It reflects initial feedback from iMHA officials including adding clearer objectives in relation to embedding Te Tiriti.

5. We have retained the six priorities from the previous version with some relatively minor wording refinements, identified in the overview of the priorities in paragraph 23 below. Each priority has between four and eight objectives sitting

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underneath them. We expect these objectives to continue to be refined in subsequent versions.

6. In setting clear expectations of what is important for the next two years – the 'what' – in the draft iGPS we have sought to avoid getting into excessive detail of 'how' the health entities will go about delivering. This approach seeks to give health entities an appropriate degree of freedom to use the NZ Health Plan to articulate how they intend to deliver on the expectations set by the iGPS.

7. The draft iGPS is intended as a public facing document in accessible language and form that articulates the key priorities and provides a high-level description of how they will be monitored. We have included measures as examples in this version of the document. Further work is required to finalise the primary measures and a supporting suite of indicators as part of the next phase of iGPS development.

8. In some areas where you have specific expectations for the health system, more prescriptive expectation-setting may be appropriate; and we have included some more detailed measures to reflect commitments and priorities you have expressed to date (for example, relating to mental health and addiction services).

9. As we have discussed with you previously, the iGPS will need to balance areas in which you wish to set more directional, high-level expectations (i.e., where entities will have greater autonomy to design solutions), with areas where your expectations may be more specific, measurable or necessitate particular actions. For the latter, we anticipate that more specific expectations for inclusion in the iGPS or technical appendices may derive from:

   a. Service performance expectations which are set for planning purposes and which drive volumes and costs – for instance, assumptions on planned care and hospital utilisation. You will receive advice on these in April to communicate expectations to entities for budget and planning.

   b. Indicators which are included in the overarching monitoring framework for Day 1 – these will draw focus and indicate measurable areas where progress is expected and will be monitored by Ministers. You will receive advice on the monitoring framework later in April.

   c. New or existing programmes where funding has been provided with clear delivery milestones or targets attached (e.g., ongoing delivery of the mental health programme, or new initiatives agreed in Budget 2022). In some of these cases, the iGPS can reinforce milestones in the coming two years.

10. As the draft iGPS is further refined you might want to take a more prescriptive approach when setting expectations for other Government priorities and provide further detail above those areas noted above; we seek your feedback on other areas where you consider that such prescription may be desirable.

## The draft iGPS sets expectations for discussions on the interim New Zealand Health Plan

11. The Pae Ora (Healthy Futures) Bill requires that the New Zealand Health Plan must give effect to the Government Policy Statement. The draft iGPS sets

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expectations for the parameters of the iNZHP which is being developed simultaneously by the interim health entities for your approval.

12. The interim health entities are working together to develop initial priorities and the approach to the interim New Zealand Health Plan (iNZHP). The emerging approach seeks to embed a 'waka hourua' model which positions both agencies as working in close partnership. The output of early thinking has been tested with both boards, including initial proposals for areas of priority in the health plan and potential health gains in the first two years.

13. Subject to your agreement that the draft iGPS can be shared with the interim health entities, we will discuss with them how the iGPS priorities cascade as intended into the iNZHP. This will enable advice on the alignment of the two documents at the time of our next iteration of the iGPS in early May.

14. As part of this we will also discuss with the interim health entities the level of prescription adopted in outlining priorities and activities in the iGPS, as noted in paragraph 9 above.

### We will continue to refine the draft iGPS subject to further advice on monitoring arrangements and Budget 22 decisions

15. As above, further advice on entity and system monitoring arrangements for day 1 and the first two years of the reformed system will be delivered to you in April. We will reflect this advice, which will include detail about accountability arrangements, in the next iteration of the iGPS, and within the technical appendices that we are developing as a companion to the iGPS.

16. The next version of the iGPS will also reflect additional advice that we will provide to you in April about updated Letters of Expectations for the new entities.

17. The Vote Health Package for Budget 2022 is under active consideration and remains "sensitive" until Budget Day, 19 May 2022. After this date the draft iGPS will be updated to reflect budget decisions.

18. We expect that the iGPS will include a brief high-level description of the multi-year allocation and the change in appropriations, and report the funding in each category (rebase, cost-pressures, and new initiatives). We expect that it might also specify initiatives that are to be funded within baselines, as you have already indicated one new initiative you would like flagged in this way.

## Overview of the draft iGPS

19. The new introduction discusses the purpose of the iGPS, the opportunity the reforms present, achieving the five shifts over time, and the critical progress needed over the next two years. We have not at this stage drafted the forewords for the Minister of Health or the Director-General of Health and envisage that some of the material currently in the introduction might be moved into these forewords in the next version.

20. The six priority chapters in the draft iGPS follow an intervention logic, which enables the following to be demonstrated for each priority:

    a. why does this matter?

    b. outcomes we are working towards

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c. how this priority gives effect to Te Tiriti

d. objectives for 2022-2024

e. an outline of how we will measure progress (with monitoring detail to be included in the technical appendices).

21. The result is that priorities are now positioned within a wider people-centred narrative, to achieve a balance between setting an aspirational vision with people's health and wellbeing at the centre, while also setting priorities and expectations for the health system to achieve it.

22. To support more consistent framing across the document, we have reflected the approach and direction set out in Whakamaua: Māori Health Action Plan 2020-25 (Whakamaua) across all priorities.

23. Specific changes include:

a. **Priority 1 - Embedding Te Tiriti o Waitangi across the health system** (previously titled *Embedding Te Tiriti o Waitangi*). The main change to this chapter has been to better align the focus and the objectives with Whakamaua. The framing of this chapter uses the accepted framing of Te Tiriti for the health system and builds on the priorities and objectives agreed in Whakamaua. Ministers have indicated that Whakamaua remains the basis for Māori health policy [HR20220440 refers], especially as it is the vehicle for progressing the majority of recommendations from stage one of Wai 2575. In response to feedback from iMHA, more detail has been added to the objectives table in this chapter.

b. **Priority 2 - Laying the foundations for the ongoing success of the health system** (previously titled *Laying the foundations for the future system*). This chapter is largely the same as the previous version except for a strengthened focus on the use of technology and health information for people and communities.

c. **Priority 3 - Keeping people well in their communities** (previously titled *Keeping people well and independent at home*). The changes to this priority strengthen the focus on providing more care closer to where people live, and on population and public health. The changes utilise the work the Ministry has been conducting on the Pae Ora Commissioning Framework, which centralises service commissioning on people and their whānau. The Pae Ora Commissioning Framework is a project under Whakamaua.

   We have added emergency, specialist services and hospital networks to this priority with a focus on identifying and tackling unjustifiable variation in access and health outcomes.

d. **Priority 4 - Achieving equity in health outcomes** (previously titled *Achieving equity in system performance*). This chapter has been revised to focus squarely on equity and the enablers of equity for different population groups. The system improvement components in the previous version, such as a whole-system approach to improving the quality of health services, have been removed. These will instead be incorporated where necessary into the monitoring framework.

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Changes to this priority have focused on ensuring that the objectives are strongly aligned to the equity goals of the Government, identifying those key equity objectives and the particular groups they support.

**Priority 5 - Developing the health workforce of the future** (previously titled *Developing the workforce of the future*). This chapter is largely the same, but overall the workforce priority area is less prescriptive about how the identified outcomes will be achieved, including detail about what the system-wide plan for the development of the health workforce will contain. However, the objective to embed Te Tiriti o Waitangi across all areas of workforce development is now more detailed in response to iMHA feedback.

e. **Priority 6 - Ensuring a financially sustainable health system** (previously titled *Ensuring a financially sustainable system*). In this chapter we have shifted focus more on the value and benefits of spending rather than cost and financial indicators. We have also added reference to climate sustainability with an objective of reducing the health system's environmental impact through the requirements of the Carbon Neutral Government Programme.

## Plan for stakeholder engagement

22. As signalled in the 16 March briefing, we have now finalised an integrated plan for stakeholder engagement (Annex 2), based around you and your Associate Ministers' involvement with support from the Director-General of Health, the Director of the Health Transition Unit and inter-agency Chief Executives.

23. This integrated approach will engage a wide range of stakeholders in thematic online sessions, complemented as required by a small number of more targeted stakeholder meetings led by officials.

24. The following sessions are suggested for April – June:

    a. Embedding Te Tiriti o Waitangi into the health system (late April)

    b. Improving equity in the health system (late May)

    c. Strengthening population and public health (early June)

    d. Improving primary and community care and / or Improving hospital and specialist services (late June).

25. Each session will provide an overview of the reform work to date and what the next few months will look like, covering key system building blocks such as the Health Charter, NZ Health Plan, localities and iwi-Maori partnership boards. These sessions will run in parallel to more in-depth engagement on the iNZHP by the interim health entities in May and June.

26. The sessions will set the iGPS in this context, explaining how it fits in with the rest of the reformed system, its intended purpose and the government priorities and measures contained within it.

27. The intended audience for these workshops includes key stakeholders in the health sector, peak bodies, and community and advocacy groups. While specific audiences will be targeted to each session (for example the session on equity will

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be tailored for Pacific, ethnic and disability communities), sessions will be open to any interested stakeholder.

28. Information will be provided to key stakeholders prior to the sessions, allowing them to decide which one(s) they choose to attend. Each session will have time for Q&A where attendees can ask questions, with the option of sending questions to the Ministry prior to the live session via email. Sessions will be recorded to share for those unable to join the event.

29. Your office has given a preliminary indication of your availability during the proposed weeks. We propose the Associate Ministers be invited to attend the sessions related to their portfolio interest and capacity to do so. Associate Ministers will be given the option of attending virtually or providing a recorded message if they are unable to attend.

## Next steps

30. We seek your broad comfort with the content and form of the draft iGPS, any specific feedback you have on the document, and your agreement for us to share this version with the boards of the iMHA and iHNZ.

31. We will provide you with further details of the accountability and monitoring framework for the iGPS in April 2022, alongside the proposed service performance expectations for the Budget Estimates process, and Letters of Expectation to support entity planning intentions.

32. We will continue to refine the draft iGPS and make consistency edits in April and May, as we receive further feedback from the interim health entities, Budget sensitive material becomes available, and we receive your feedback and decisions on upcoming advice on the accountability and monitoring framework.

33. We will provide you with a further draft of the iGPS in early May. This version will include drafts of the technical appendices with advice on their form and how they are best presented in relation to the narrative part of the iGPS.

34. The timeline for completion of the iGPS from that point is as follows:

    a. engagement late April – late June (via the engagement plan in this briefing)

    b. final draft iGPS to you late May / early June

    c. publication / public release late June.

35. We seek your agreement to commence detailed planning of the stakeholder engagement sessions, starting with confirming dates in the diaries of you and your Associate Ministers.

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## Annex 2: Integrated health reform engagement plan April – June 2022

| Session | What this session may cover | Suggested timeframes | Suggested presenters |
|---|---|---|---|
| 1. Embedding Te Tiriti o Waitangi into the health system | • The health system will reinforce Te Tiriti o Waitangi principles and obligations to address historic inequity and provide a strong voice and influence for Māori<br>• How key components and documents will work toward this aim (eg iGPS, NZ Health Plan, Health Charter, Iwi-Māori Partnership Boards) | **Week of 25 April**<br>*(Note 25 April is ANZAC Day)* | Minister Little<br>Minister Henare<br>Director-General of Health<br>Chief Executive of interim Māori Health Authority<br>Chief Executive of interim Health NZ |
| 2. Improving equity in the health system | • How the system will work to achieve equity in system performance for different population groups with a focus on Pacific and ethnic communities and disabled people<br>• This will include the key components and documents | **Week of 23 May** | Minister Little<br>Minister Sio<br>Director-General of Health<br>Chief Executive of interim Health NZ |
| 3. Strengthening population and public health | • How the system improves population and public health and prevention through the establishment of the Public Health Agency, Public Health Service and public health operating model<br>• This will include the key components and documents | **Week of 6 June**<br>*(Note 6 June is Queen's Birthday)* | Minister Little<br>Minister Verrall<br>Director-General of Health<br>Chief Executive of interim Health NZ<br>Chief Executive of interim Māori Health Authority |
| 4. Improving primary and community care and / or Improving hospital and specialist services | • Highlighting Government's critical system shift to increase access to a wider range of health services provided in the home and in communities<br>• Actions to strengthen emergency and specialist services and hospital networks and address variation in access and health outcomes<br>• How key components and documents will work toward this aim | **Week of 20 June**<br>*(Note 24 June is Matariki)* | Minister Little<br>Director-General of Health<br>Chief Executive of interim Health NZ<br>Chief Executive of interim Māori Health Authority |

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Document 4

MINISTRY OF HEALTH
MANATŪ HAUORA

# Briefing

## Further update on the interim Government Policy Statement (iGPS) – refined narrative and proposed iGPS measures

| | | | |
|---|---|---|---|
| **Date due to MO:** | 13 May 2022 | **Action required by:** | 19 May 2022 |
| **Security level:** | IN CONFIDENCE | **Health Report number:** | 20220840 |
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Copy to:** | Hon Peeni Henare, Associate Minister of Health | | |

## Contact for telephone discussion

| Name | Position | Telephone |
|---|---|---|
| **Dr Ashley Bloomfield** | Director-General of Health | s 9(2)(a) |
| **Stephen McKernan** | Director, Health Transition Unit | s 9(2)(a) |

## Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

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# Further update on the interim Government Policy Statement (iGPS) – refined narrative and proposed iGPS measures

| Security level: | IN CONFIDENCE | Date: | 13 May 2022 |
|---|---|---|---|
| To: | Hon Andrew Little, Minister of Health | | |
| Copy to: | Hon Peeni Henare, Associate Minister of Health | | |

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## Purpose of report

1. This report provides you with an update on the development of the interim Government Policy Statement (iGPS). It includes a refined narrative version of the iGPS, which incorporates further feedback from the iMHA board and officials, and proposed measures for each priority chapter.
2. It seeks:
   a. to test your comfort with the refined iGPS (Annex 1), and your feedback on the proposed 'basket' of measures for each priority chapter (the iGPS measures);
   b. your agreement that we share the iGPS measures with the iMHA and iHNZ for their feedback, alongside the refined version of the iGPS. This would be our final round of engagement with the entities on the iGPS narrative content.
3. This report also includes next steps to finalise the iGPS, including advice you will receive next week to inform your decision-making on possible iGPS technical appendices; and our intention to provide you with a near final iGPS in early June seeking your agreement to take it through the Ministerial Oversight Group.
4. This report discloses all relevant information and implications.

## Summary

5. On 8 April 2022 we provided you with the first draft narrative version of the iGPS [HR 20220424 refers]. On 11 April 2022 you indicated that you were broadly comfortable with the direction of emerging structure and content. We incorporated your comments and sent it to the iMHA and iHNZ for further feedback by the end of April.
6. We have since received further feedback from the iMHA board and worked with their officials to refine language and content, particularly in the Te Tiriti o

Waitangi chapter where we have sought to achieve a balance between reaffirming Whakamaua as Government policy and agreed action plan for Māori health while creating scope for the Māori Health Authority to identify and progress further priorities over the biennium. .

7. We have not yet received feedback from iHNZ however we have recently received the interim NZ Health Plan and work is underway to ensure it aligns with priorities in the iGPS. This alignment, and any further feedback from iHNZ, will be evident in the next and final version of the iGPS for your approval.

8. Annex 2 includes a proposed 'basket' of measures for each priority chapter. These measures intentionally apply to multiple objectives across the document.

9. We are keen to discuss with you the number, focus and emphasis of the measures. Subject to your feedback, we will work with iHNZ and iMHA to further refine these measures into a final suite for your approval as part of the final iGPS.

10. Next week, we will provide you with separate advice to inform your decision-making on how iGPS technical appendices could be finalised.

11. In the meantime, we want to test your comfort with the refined iGPS content, which outside of the Te Tiriti o Waitangi chapter has not changed significantly, and seek your agreement to share this and the iGPS measures with the entities for a final round of feedback.

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Document 4

## Recommendations

| | We recommend you: | |
|---|---|---|
| a) | **Note** that further feedback from the interim Māori Health Authority (iMHA) has been incorporated into a second draft narrative version of the interim Government Policy Statement (the draft iGPS) attached at Annex 1. | |
| b) | **Note** that we have not yet received feedback from interim Health NZ (iHNZ) but have recently received a copy of the interim NZ Health Plan and work is underway to ensure the priorities in the iGPS cascade into the plan as intended. | |
| c) | **Note** that we will continue to refine the draft iGPS to reflect further feedback from interim health entities; decision-making by you in May on possible iGPS technical appendices; Budget 22 decisions; and design, proofreading and consistency edits. | |
| d) | **Provide feedback** on the draft iGPS and the proposed iGPS measures. | **Yes / No** |
| e) | **Agree** that the Ministry can share the draft iGPS and the iGPS measures attached at Annex 2, with the iMHA and, subject to their feedback and any necessary changes, the iHNZ for further feedback. | **Yes / No** |
| g) | **Note** that we will incorporate additional interim health entity feedback and come back to you with a final draft iGPS for approval in early June. | |

pp.

Dr Ashley Bloomfield
**Director-General of Health**
Date: 13/05/2022

Stephen McKernan
**Director, Transition Unit**
Date: 13/05/2022

Hon Andrew Little
**Minister of Health**
Date:

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# Further update on the interim Government Policy Statement (iGPS) – refined narrative and proposed iGPS measures

## Context

12. On 8 April 2022 we provided you with the first draft narrative version of the iGPS [HR 20220424 refers]. On 11 April 2022 you indicated that you were broadly comfortable with the direction of emerging structure and content. We incorporated your comments and sent it to the iMHA and iHNZ for another round of feedback by the end of April.

13. We have since received additional feedback from the iMHA Board and worked with their officials to refine content and language, predominately to the Te Tiriti o Waitangi chapter. We have not yet received further feedback from iHNZ.

## Further iMHA feedback

14. We met with the iMHA board on 27 April on the draft iGPS with their feedback summarised as follows:

    a. Overall, the document has come a long way and they have a sense that their feedback is being incorporated.

    b. The principles of Te Tiriti should be included in the iGPS.

    c. Social determinants are still not well integrated enough through the document.

    d. There is an imbalance in chapter one between the focus on Whakamaua and the role of the Māori Health Authority; they value Whakamaua and the direction and guidance it provides but the MHA needs room to exercise its role and authority.

    e. They recognise we are still working on the measures but want to be sure that what will be provided is different from what is currently happening. The focus should be on a vital few priorities with the flexibility to evolve the measures over time.

    f. They are concerned about the consistency of language in references to Te Tiriti o Waitangi across the iGPS and draft NZ Health Plan.

    g. Rural communities and disabled people including tāngata whaikaha need more visibility.

## The refined draft iGPS addresses most of the iMHA feedback

15. The refined draft narrative version of the iGPS attached at Annex 1 addresses the iMHA board's feedback and has been reviewed by iMHA officials. We have made updates to recognise that Whakamaua is a starting point to direct and guide

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progress over the next two years, but there is flexibility for the MHA and health entities to make progress beyond this.

16. We have incorporated the iMHA recommendation that priority 1 explicitly notes that the iMHA board, and Iwi will build on Whakamaua and that new approaches to working with Te Tiriti in an effective and meaningful way are relevant to the context of system transformation. We have also sought to be more consistent and deliberate about the verbs used to reference Te Tiriti. As work progresses on the iGPS and the interim NZ Health Plan, we will establish a review progress involving subject matter experts to ensure consistency across the documents.

17. References to the determinants of health, rural communities and disabled people including tāngata whaikaha have been strengthened where appropriate; however, we will want to seek further feedback on this from iHNZ to ensure these aspects have the right balance and visibility in the document, particularly in relation to rural communities.

18. The Te Tiriti chapter currently makes an explicit reference to the Articles of Te Tiriti, at the request of the iMHA. We are concerned to ensure that this does not create any presentational or legal risk regarding the health system's obligations, in the context of the Pae Ora Bill and Ministers' considered decisions to not include direct reference to Articles (including rangatiratanga) in the health sector principles. s 9(2)(h)

19. There are two additional areas of feedback from iMHA officials that we have not yet addressed, which we will consider and discuss with iMHA for possible reflection in the next version of the document. These are:

    a. the Tiriti section under 'Priority 4: Achieving equity in health outcomes' should be strengthened, explicitly exploring equity of outcomes for Māori

    b. the Tiriti section under 'Priority 5: Developing the health workforce of the future' could be reframed to better emphasise the role of the whole, diverse workforce, not just the mainstream workforce.

20. Finally, we have moved some text from the introduction section of the previous version into the Minister's foreword section.

## We propose a 'basket' of measures for each priority chapter

21. The previous version of the iGPS included examples of measures. We have further developed these and are now proposing a 'basket' of measures for each priority chapter. These are set out in the table in Annex 2, along with the rationale for each basket and commentary and questions where we are seeking a steer from you.

22. The proposed measures have been selected as markers of progress towards the priorities and objectives in the iGPS over the first two years of the reformed system. These measures intentionally apply to objectives across multiple chapters.

23. At this stage, the combined baskets of measures include 33 measures which we think would provide indications of system and agencies' progress towards the iGPS priorities over the first two years of the reformed system. We have

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developed them building from measures available today (including Estimates measures, Health System Indicators and Whakamaua measures), and analysis of the kinds of measurement which might give confidence of high-level progress towards iGPS objectives.

24. These measures do not replace Health System Indicators, which retain their current status and reporting process. Instead, indicators with good alignment to the reform changes have been included in the 'basket' of iGPS measures. The wider accountability and monitoring framework for the reformed system will also include Health System Indicators, iGPS outcomes and measures, and service level indicators that both HNZ and MHA will report on.

25. Work on iGPS measures is still relatively early – and subject to your feedback., We would expect significant further refinement working with iHNZ and iMHA before confirming final measures for inclusion in the final iGPS.

## Example of how iGPS measures will sit alongside monitoring measures

26. The proposed iGPS measures will sit alongside measures for entity monitoring, delivery monitoring against the interim NZ Health Plan (which is defined by milestones as well as measures), and system monitoring (with a broader, longer-term view of how the system is performing) to provide a holistic view of system performance and reform progress.

27. To that end, the iGPS measures will not reflect all the aspects of entity and system performance that you are interested in. Some of those things are not amenable to monitoring or measurement through two-year measures. These might instead be tracked through deliverables (to keep an eye on short-term, specific actions needed) or system monitoring that brings together quantitative and qualitative performance measures with longer-term outcomes measures.

28. For example, for the health workforce (chapter 5), the iGPS measures are a few high-level markers which we would expect to shift over the next two years if things are going well. Out of the interim NZ Health Plan, there will be a series of deliverables which need to be landed over the next two years, but which may not significantly affect outcomes in that time period – e.g. delivering data as to the size and scale of our workforce, delivering innovative education and training programmes.

29. There are then outcomes which, as system monitors, we will want to see move but which will take longer or might not be directly aligned to the iGPS objectives which are set at a two-year horizon. For example, significant changes in the composition of the workforce between professions are desirable, and are relevant for system monitoring, but will not significantly shift over the next two years.

30. While the contents of most of the 'baskets' are measures, we have included some milestone objectives in the proposed iGPS measures, because in a few areas, most of the things that deliver on the iGPS objectives are milestones. We would like to have a conversation with you about your comfort with this approach, or whether you prefer not to include milestones in iGPS measures in favour of a more explicit link to the interim NZ Health Plan.

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31. We are keen to discuss with you the number, focus and emphasis of the measures. Subject to your feedback, we will work with iHNZ and iMHA to further refine these measures into a final suite for your approval as part of the final iGPS. Alongside this, advice on monitoring frameworks will more clearly depict the relationship between iGPS measures, iNZHP milestones and measures, and broader entity and system monitoring.

## The iGPS technical appendices

32. As discussed with you on 5 May 2022, there are a number of existing expectation-setting documents in the health system, and decisions need to be made about whether they are still needed, and if so, where they best sit. We understand that in general the iGPS reflects the Government's strategic direction for the health system and you do not expect to include a lot of detailed existing measures in it.

33. At a minimum, we expect to have two appendices to the iGPS:

    a. one providing technical definitions and requirements for the iGPS measures;
    b. the framework for monitoring and reporting required by the Pae Ora Bill.

34. We will provide you with separate advice next week to support your decision-making on the iGPS technical appendices.

## Next steps

35. We seek your feedback on the draft iGPS and proposed iGPS measures. Subject to your feedback, we also seek your agreement to share these with the interim entities for their comment before the document is finalised.

36. On 19 May 2022, we will provide you with further advice on the iGPS technical appendices.

37. The Vote Health Package for Budget 2022 remains "sensitive" until Budget Day, 19 May 2022. After this, the iGPS will be updated to reflect budget decisions.

38. From there, we plan to send you a near final version of the iGPS in early June, seeking your agreement to send it to the Ministerial Oversight Committee for final approval and agreement to publish in late June.

39. There are three webinars on the iGPS in the context of the wider health reforms scheduled in June. These are:

    a. Improving equity in the health system (Wednesday 1 June 11.30am – 12.30pm).

    b. Strengthening population and public health (Wednesday 8 June 11.30am – 12.30pm).

    c. Improving primary and community care and / or Improving hospital and specialist services (Thursday 23 June 11am – 12pm).

40. We will provide separate briefings and speaking notes ahead of each webinar.

41. Finally, the Ministry received a copy of the interim NZ Health Plan on 7 May 2022. As part of our review of the health plan we will advise on its strategic alignment with the iGPS, ensuring that the iGPS priorities cascade as intended into the health plan.

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## Annex 1: Draft interim Government Policy Statement (iGPS)

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## Annex 2: Proposed iGPS measures

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# Annex 2 – List of proposed iGPS measures

**Table: Long list of interim Government Policy Statement measures**

| iGPS Priority | Specific iGPS measures for priority area | Rationale for basket of measures | Commentary and Ministerial steers |
|---|---|---|---|
| **Embedding Te Tiriti o Waitangi across the health system** | Where we will see desired change in trends at national, regional and district levels:<br>1. Funding received by kaupapa Māori health service providers (Whakamaua measure 1.1, compiled from sector financial information)<br>2. Experience of health services for Māori as measured by the primary health care and adult inpatient patient experience surveys (Whakamaua measure 2.1, survey conducted by HQSC).<br>3. Geographical coverage and utilisation of rongoā Māori service (Whakamaua measure 1.2, compiled from Rongoā provider reporting)<br>4. Qualitative feedback from the IMPBs on how they are fulfilling their role and whether they are receiving the support they require (replacing Whakamaua measure 4.1, a new survey to be conducted by the Ministry)<br>5. Reduction in differences between Māori and non-Māori in wait times between screening and treatment for breast, cervical and bowel cancer services. | These measures together reflect:<br>• Accelerating the spread and delivery of kaupapa Māori and whānau-centred services (in general terms, and in relation to rongoā services specifically).<br>• Patient feedback on health system shifts to confirm whether there is a perceived increase in the provision of culturally safe services, and improved choice of service so that iwi, hapū, whānau and Māori communities can exercise their authority to improve their health and wellbeing.<br>• IMPB feedback to confirm shifts in health system engagement is fair and sustainable, and delivers more equitable outcomes for Māori.<br>• Action to address disparities in wait times and treatment between Māori and non-Māori for cancer services. | The basket takes five of the existing measures already approved by the Government in Whakamaua, drawing on the themes most closely related to the iGPS priority. Many of the other Whakamaua measures appear in baskets for the other priority areas. Monitoring of this priority will draw on most of the measures across the baskets, as all measures wherever possible will be differentiated by ethnicity.<br><br>**We will engage with health entities to ensure that this basket and the wider set of measures adequately covers the key objectives for embedding Te Tiriti** |
| **Laying the foundations for the ongoing success of the health system** | Where we will see desired change in trends at national, regional and district levels:<br>1. Health entities are clear about their own and each others' roles and responsibilities, and are delivering to these (monitor's assessment, informed by discussion with entities – to include a maturity and activity assessment by domain to be completed by June 2024).<br>2. Experience of health services for across demographic groups as measured by the primary health care and adult inpatient patient experience surveys (survey conducted by HQSC).<br>3. Feedback from public engagement on public accountability processes such as Health Plan. HNZ and the MHA will publish a feedback report similar to the latest Hui Whakaoranga report (https://www.health.govt.nz/system/files/documents/publications/hui-whakaoranga-2021-summary-report-v5.pdf)<br>4. Proportion of appropriate outpatient appointments completed through digital channels | These measures together reflect feedback on new system roles, structures and relationships:<br>• Board and leadership feedback on clarity of roles and responsibilities to confirm that new system settings are supported to be successful.<br>• Staff feedback to confirm alignment of operations with the Health Charter and new ways of working.<br>• Public satisfaction confirms the shift of engagement regarding public input into accountability processes such as Health Plan is meaningful.<br>• Patient feedback to confirm that their voice is more meaningfully heard and involved in decisions about them.<br>• Expanding access to digital models of support will help to keep people well in their communities | This basket contains fewer proposed measures, owing to the focus of the priority area on system structures, processes and relationships, which are not all currently measurable. Measurement in some cases will require the use of existing survey vehicles to return information during the first two years and /or information from staff engagement surveys that will be established.<br><br>The fourth measure, feedback from public engagement, would be a composite of analysis of feedback from public engagement exercises.<br><br>This basket could be supplemented by milestone-based measures (e.g. related to delivery of critical processes or outputs for the reformed system).<br><br>**Is the Minister interested in principle in adopting milestone measures to provide further specificity for monitoring?** |
| **Keeping people well in their communities** | Where we will see desired change in trends at national, regional and district levels:<br>1. Proportion of people (reported by ethnicity) reporting unmet need for primary health care (Whakamaua measure 1.3, collected In the New Zealand Health Survey)<br>2. Percentage of people waiting for planned specialist care who receive it within four months reported by ethnicity (collected in the planned care data systems)<br>3. Number of days spent in hospital for unplanned care including emergencies reported by ethnicity and geography (HSI and Whakamaua measure 4.4, collected through the National Minimum Data Set for inpatients)<br>4. Uptake of immunisations for key age groups, reported by ethnicity and geography (his, collected through the National Immunisation Register and the National Immunisation system).<br>5. Rate of hospital admissions for children under five for an illness that might have been prevented or better managed in the community (HIS and also Whakamaua 3.1, collected through the National Minimum Data Set for inpatients)<br>6. Rate of hospital admissions for people aged 45 to 64 for an illness that might have been prevented or better managed in the community (HSI, collected through the National Minimum Data Set for inpatients)).<br>7. 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 June 2024<br>8. Enrolment with an LMC in the first trimester of pregnancy by ethnicity<br>9. Standardised rate of acute readmissions within 28 days of discharge | These measures together reflect key outcomes related to the effect of prevention, public health and primary care:<br>• Improved access to primary care and reduction in unmet need to support system shift toward communities.<br>• Reduction in unnecessary hospital care (and length of stay in hospital) for different groups to support system shift towards prevention.<br>• Improved experience of the interface between primary and secondary care.<br>• Increasing preventive health care (immunisations).<br>• Evidencing that specialist health services, including specialist mental health services, are delivered in a timely manner and support return to communities.<br>• Expanding access to and choice of mental health and addiction support in community settings is a priority programme<br>• Readmission within 28 days is a standard system effectiveness measure | This priority area covers broad ground, including population and public health, prevention, primary and community care. The potential basket therefore includes a range of measures which derive from existing collections.<br><br>Overall, the ten possible measures proposed here are too many, and could create an imbalance across the iGPS. We intend to reduce this to 5/6 in line with the other priorities.<br><br>Subject to your steer, we would propose streamlining this basket by (i) bringing together measures of availability and unmet need – currently 1, 3 and 7 in the basket; and (ii) combining measures for avoidable hospital admissions – currently 7, 9 and 10.<br><br>**Which of these measures would you wish to prioritise for inclusion in this basket?** |

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## Annex 2 – List of proposed iGPS measures

| iGPS Priority | Specific iGPS measures for priority area | Rationale for basket of measures | Commentary and Ministerial steers |
|---|---|---|---|
| **Achieving equity in health outcomes** | Where we will see desired change in trends at national, regional and district levels:<br>1. Reduction in variation of clinical prioritisation for cancer treatment and elective surgery by both geography and ethnicity (collected through the planned care data systems).<br>2. Reduction in variation in the rates of access to key identified services by ethnicity, geography and other characteristics. Initial areas include surgery, first specialist assessments, gender affirming care:colonoscopies,, access to specialist mental health (including for Rangatahi - Whakamaua 3.2); and screening). Data drawn from various health system data sets.<br>3. Reduction in missed appointments for specialist care by ethnicity and geography (collected through the National Non-admitted Patient Activity Collection).<br>4. Reduction in the proportion of Did Not Attends for Maori and Pacific Peoples compared to non-Maori / non-Pacific, paired with standardised rate of FSAs / Follow-ups.<br>5. Reduction in the rate of diabetes complications and inequities between ethnicities (Whakamaua 3.3, collected through the National Minimum Data Set for inpatients) | These measures together reflect the most significant areas of variation and inequity between groups:<br>• Patient feedback on health system shifts to confirm that they feel they have stronger ownership of their health care.<br>• Reductions in geographic and ethnic variation in clinical prioritisation confirms greater consistency in clinical prioritisation to determine priority for specialist services for all groups.<br>• Reduction in geographic and ethnic variation confirms greater consistency in access to specialist services for all groups.<br>• Reduction in inequity in the rates of missed specialist appointments, confirming that specialist health services are more accessible and relevant, especially for Maori.<br>• Reduction in inequity in acute bed day rates in hospital, to confirm that community health and alternative health services are more equitably accessible, especially for Maori.<br>• Diabetes is a major long-term condition that disproportionately impacts Māori and Pacific people, and it is a condition that has significant downstream impacts and costs for whānau and the health system. | This basket has overlap with other priority areas, given the cross-cutting nature of the equity objective. Our aspiration is that all measures in the iGPS will be disaggregable for different groups to support analysis of equity in all areas.<br><br>**Are you content to capture measures in more than one basket, or would it be clearer to include once but note that many will be relevant to more than one priority area?**<br><br>Measures 3 and 4 include a range of components which need to be prioritised to determine the appropriate lead measures.<br><br>**Are there particular aspects of variation of access that you would wish to see included from those identified?** |
| **Developing the health workforce of the future** | Where we will see desired change in trends at national, regional and district levels:<br>1. Engagement survey of staff on culture and shift towards one team ethos (charter to inform this).<br>2. Percentage of Māori in the regulated workforce compared with the percentage of Māori in the population (Whakamaua measure 2.3 measured from data from the Professional Councils)<br>3. Percentage of other demographic groups in the regulated workforce compared with the percentage in the population (measured from data from the Professional Councils).<br>4. Increase in number and diversity of enrolees entering training programmes to become a registered health professional (including rural training), measured form data from the education sector<br>5. Number and percentage of Māori in leadership and governance roles across the Ministry, DHBs and health sector Crown entities (Whakamaua measure 4.3) (reported by the entities)<br>6. Number and percentage of Pacific people in leadership and governance roles across the Ministry, DHBs and health sector Crown entities (reported by the entities) | These measures together reflect some of the key issues identified in the priority area:<br>• Staff feedback confirms alignment to a 'one team ethos' is embedding across health entities.<br>• Evidencing an increase of supply for the future health workforce including significant gap areas and across ethnic groups.<br>• Participation in the health workforce and its leadership for under-represented groups, in particular Māori, Pacific and disabled people. | This basket is focused on workforce representation and training routes, reflecting the current data sets. There is currently limited staff experience data and no national staff survey vehicle, but this could be an area for rapid development in the first two years.<br><br>**Would you like to include Pacific and disabled people in measure 2?**<br><br>**Are you interested in advice on options for improving workforce experiential data, and potentially including related placeholder measures?** This could support new measures in relation to perceptions of staff capacity and capability, use of skills, access to training etc. |
| **Ensuring a financially sustainable health system** | Where we will see desired change in trends at national, regional and district levels:<br>1. Actual expenditure is consistent with budgeted and, overall budgeted and actual expenditure balances.<br>2. Ongoing improvements in agreed measure of quality-adjusted, system-level productivity<br>3. % spend on mental health, public health, and primary and community care increases over time, across all entities in the system<br>4. Planned maintenance and capital expenditure is delivered OR Delivery of Asset Management and Capital Capability Plan | These measures together reflect system-level and entity-level financial sustainability:<br>• Managing expenditure is an entity-level measure, but during the transition period we considered that this would be a headline measure of sustainability and financial management and, in practice, would not be assessed separately from value.<br>• While the key priority for capital investment is building relevant capability and capacity, we considered that perhaps this might be measured by its short term outputs, including delivering plans and projects.<br>• A system-wide productivity measure, that properly accounts for changes in quality and brings in a wide range of outputs, such as those developed internationally, provides a way of keeping the whole system's strategic focus on value for money. | We have tried to focus at the system level on indicators that are affected by multiple organisations and determinants, however to be meaningful and to focus attention on key dimensions there is also granularity including in an indicator of budget balance.<br><br>We considered that, at least in the short term, we need to monitor inputs for key areas where investment is likely to have high payoffs, given that outcomes accrue over time and are often hard to measure and attribute (mental health, public health & prevention).<br><br>If you want a system-wide productivity measure, we will develop this with MHA and HNZ, with a first draft available in year 1.<br><br>**There is an option to consider a measure for climate sustainability as per the iGPS – would you like to include this?** |

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Document 5

**DEPARTMENT OF THE PRIME MINISTER AND CABINET**
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

MINISTRY OF HEALTH
MANATŪ HAUORA

# Briefing

# APPENDICES TO THE INTERIM GOVERNMENT POLICY STATEMENT

| To: Hon Andrew Little, Minister of Health; Hon Peeni Henare, Associate Minister of Health. | | | |
|---|---|---|---|
| **Date** | 27/05/2022 | **Priority** | Routine |
| **Deadline** | 01/06/2022 | **Briefing Number** | DPMC-2021/22-2238<br>HR20220936 |

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## Purpose

This paper seeks your agreement to the approach to including wider direction-setting material in the interim Government Policy Statement.

## Summary

1. The interim Government Policy Statement (iGPS) will set Ministers' priorities, objectives and expectations for the health system in the first two years of the reforms from July 2022. This will be the critical direction-setting document for the system, which will be given effect through the interim New Zealand Health Plan and the operational plans of health entities.

2. The iGPS is a new feature of the reformed health system and Ministers and Cabinet have been clear of its aims to consolidate direction-setting mechanisms into a clear, single vehicle to strengthen accountability to Ministers and reinforce a "one system" ethos. The objective is that the GPS will reduce the need for additional direction-setting mechanisms and streamline in-year changes or additions.

3. There are a number of direction-setting documents in the current health system which are prepared by the Ministry of Health (the Ministry) and agreed by Ministers. These documents have fulfilled different purposes in the current system, and there is a question as to whether those purposes continue in the future, and if so, how to incorporate them into the new iGPS framework. In particular, this advice considers:

   a. The Service Coverage Schedule (SCS), which sets national minimum service coverage requirements for the health system that are to be give effect through service plans in all areas.

   b. The Operational Policy Framework (OPF), which sets out core business rules for health entities based on existing statutory requirements and policy expectations.

4. There are two broad options for how you may wish to use the iGPS to incorporate direction-setting mechanisms:

    a. A broader, more encompassing approach that aims to include all relevant and supporting documents. This would take a maximal definition of 'direction-setting' and might include material that sets business or administrative requirements.

    b. A more targeted approach that aims to use the iGPS to set common core direction for the health system and includes critical material, but does not incorporate all related elements.

5. We recommend the second of these, on the basis that a targeted approach will allow the iGPS to focus on its main objective – setting Government's policy priorities and expectations – without the risk of dilution. Not all standing requirements on entities need be part of the iGPS.

6. Based on this recommendation, our assessment is that there is a case for incorporating one area into the iGPS: the framework for monitoring and reporting on system and entity performance, including against the specific metrics identified as being most relevant to the priorities in the iGPS. This information will support clarity on what Ministers aim to achieve and how this will be monitored.

7. We do not believe that other possible areas of content are necessary to include in or append to the iGPS.

8. In relation to the SCS, we believe that this should continue to be a Ministerially-mandated set of minimum service coverage expectations for the health system. These expectations should be visible and available on Day 1. However, because the SCS does not require the authority of the iGPS to have effect, and because it is likely to be amended more frequently, we do not consider it helpful to incorporate in the iGPS framework. Moreover, we recommend that the updated version for 1 July be subject to a fuller review by the Ministry and health entities, with a view to making further changes in due course.

9. In relation to the OPF specifically, our view is that there remains a rationale for a document whose intent is to consolidate various statutory requirements and present these together as a guide to health entities. However, this is the document that the new entities were concerned about including in the iGPS. It does not need to be part of the iGPS framework and can be published separately by the Ministry and shared with the health entities.

## Recommendations

a. **Note** that the purpose of the Government Policy Statement (GPS) under the Pae Ora (Healthy Futures) Bill is to set priorities for the publicly-funded health sector; and set clear parameters for the development of the New Zealand Health Plan.

b. **Note** that the intention of the Government Policy Statement is in part to consolidate existing direction-setting documents and provide for a clearer basis for accountability to Ministers.

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c. **Agree** to a targeted approach to the inclusion of direction-setting content in the iGPS, to ensure that the document remains focused on your high-level priorities and expectations for the health system. YES / NO

d. **Agree** that the iGPS include as an appendix a framework for regular monitoring and reporting, including measures against which delivery of the iGPS will be assessed by the Ministry of Health. YES / NO

e. **Note** that the Ministry of Health and Treasury have provided you and the Minister of Finance with advice on the initial system monitoring framework for Day 1 [HR 20220858 refers], and subject to Ministers' views this will form the content for inclusion in the iGPS as per recommendation (d) above.

f. **Agree** that Ministers should continue to set Minimum Service Coverage Expectations for the health system, and that this should be published to ensure clarity for 1 July 2022; but that this should not be part of the iGPS. YES / NO

g. **Note** that the Ministry of Health will work with Health NZ and the Māori Health Authority to review the Minimum Service Coverage Expectations and propose further changes to the document; and will provide advice to you on the approach to this work in due course.

h. **Note** that, if you agree to recommendation (c), the Ministry will maintain the current Operational Policy Framework as a consolidated guidance for the health system on core business rules, but this will be published separately to the iGPS and shared with health entities.

i. **Note** that if you wish to take a broader approach to the iGPS and incorporate a wider range of requirements for health entities, this will likely also include the Minimum Service Coverage Expectations, Operational Policy Framework and letters of expectation for entities.

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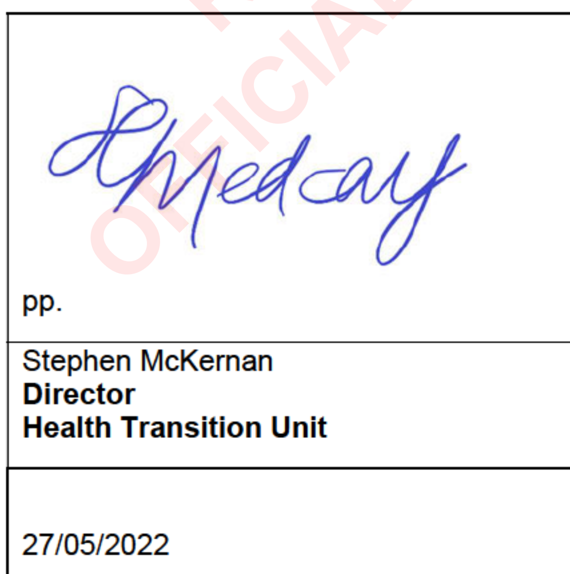
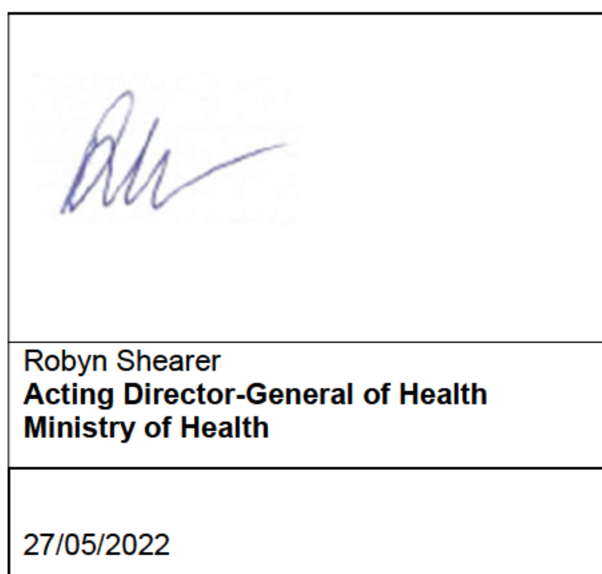
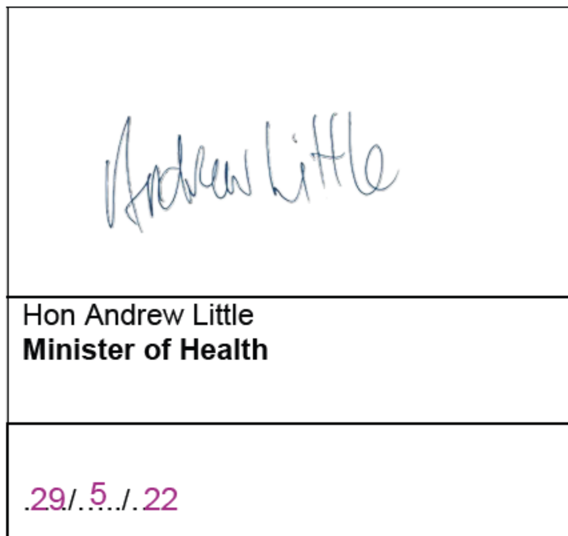
|  pp. |  |
|---|---|
| Stephen McKernan<br>**Director**<br>**Health Transition Unit** | Robyn Shearer<br>**Acting Director-General of Health**<br>**Ministry of Health** |
| 27/05/2022 | 27/05/2022 |

Document 5



| Hon Andrew Little<br>**Minister of Health** | Hon Peeni Henare<br>**Associate Minister of Health** |
|---|---|
| 29/ 5 / 22 | …../…../…. |

**Contact for telephone discussion if required:**

| Name | Position | Telephone | 1st contact |
|---|---|---|---|
| Stephen McKernan | | | |
| Simon Medcalf | Health Team Lead | s 9(2)(a) | ✓ |
| Maree Roberts | Deputy Director-General, System Strategy and Policy, Ministry of Health | s 9(2)(a) | ✓ |

**Minister's office comments:**

- ☐ Noted
- ☐ Seen
- ☐ Approved
- ☐ Needs change
- ☐ Withdrawn
- ☐ Not seen by Minister
- ☐ Overtaken by events
- ☐ Referred to

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# APPENDICES TO THE INTERIM GOVERNMENT POLICY STATEMENT

## Context

*The role of the Government Policy Statement*

1. Section 43A of the Pae Ora (Healthy Futures) Bill defines the purpose of the GPS as being to "set priorities for the publicly funded health sector; and set clear parameters for the development of the New Zealand Health Plan". In pursuit of that purpose, it is required by section 43C to include:

   a. the Government's priorities and objectives for the publicly-funded health sector;

   b. how the Government expects health entities to meet the Government's priorities and objectives;

   c. the Government's priorities for engaging with and improving outcomes for Māori;

   d. the Government's priorities for improving health outcomes for Pacific peoples, disabled people, women, rural communities and other populations; and

   e. a framework for regular monitoring of progress and reporting requirements.

2. The interim Government Policy Statement (iGPS) will set Ministerial policy and performance expectations for the health system for the first two years. The iGPS is not required to comply with the full requirements of the Pae Ora Bill for the three-year GPS, which must be issued from 1 July 2024. However, we expect that these should be followed as far as possible to show alignment with the intended approach.

3. Ministers and Cabinet have set aims for the GPS to consolidate direction-setting mechanisms into a clear, single vehicle to strengthen entities' accountability to Ministers and reinforce a "one system" ethos. Part of this objective is that the GPS will focus emphasis on common priorities and expectations, and will reduce the need for additional direction-setting mechanisms. For example, Ministers have noted the intention that the GPS would reduce the need for annual letters of expectation, at least for Health NZ and the Māori Health Authority.

*Current direction-setting documents*

4. There are a number of direction-setting documents in the current health system, which are prepared by the Ministry of Health and agreed by Ministers. These documents have fulfilled different purposes in the current system, but they have in general sought to set national requirements in the context of a landscape of 20 semi-autonomous district health boards. The key documents are:

   a. The Service Coverage Schedule (SCS), which sets national minimum service coverage requirements for the health system that are to be give effect through service plans in all areas.

   b. The Operational Policy Framework (OPF), which sets out core business rules for health entities based on existing statutory requirements and policy expectations.

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5. Beyond these documents, other mechanisms have been used regularly to set direction and system rules, including Ministerial letters of expectation to entities, Crown funding agreements, and regulations (primarily the Eligibility Direction). These have been supplemented over time with various health strategies and policy statements, albeit in a less formal and directive manner.

6. In the context of the iGPS, it is necessary to consider whether and how to incorporate these direction-setting mechanisms into the new consolidated approach. In each case, we consider what the purpose of the specific document is, whether that purpose persists in the reformed system, and what alignment or integration is necessary with the iGPS for overall coherence. We have worked with Health NZ and the Māori Health Authority to consider these questions and to test the merits of inclusion in the iGPS.

## Inclusion of appendices in the iGPS

*There are options for how you use the iGPS to incorporate direction-setting material.*

7. The iGPS represents the strongest vehicle for you to outline minimum expectations and policy settings for the future health system. The iGPS's purpose is to set Government direction and priorities, and agencies are required to give effect to it (including through the interim NZ Health Plan), which will have a significant impact on how agencies approach the first two years of the reformed system.

8. This impact necessitates a measure of balance, and it is desirable to focus on the matters of greatest importance to you, to avoid agencies' priorities being diluted. At the same time, the level of specificity in the iGPS should match the level of your expectations, so that details you want to see operationalised are clear, while giving entities the space anticipated by the reformed system operating model to translate priorities into actions.

9. We have considered two options for how you may wish to construct the iGPS to incorporate direction-setting mechanisms:

    a. A broader, more encompassing approach that aims to include all relevant and supporting documents. This would take a maximal definition of 'direction-setting' and might include material that sets specific business or administrative requirements. It would have the benefit of the iGPS framework becoming the single vehicle for direction-setting and would consolidate as much material as possible to bring greater transparency and alignment.

    b. A more targeted approach that aims to use the iGPS to set common core direction for the health system and includes critical material, but does not incorporate all related elements. This would have the benefit of ensuring the primacy of the iGPS, but while preserving some aspects of detail outside the iGPS to provide proportionality and flexibility.

10. **We recommend the second, more targeted approach.** This would recognise that not all elements need or should be part of the iGPS, and it may be disproportionate to use the iGPS in this way. For example, the iGPS should provide strategic direction to the health system as a whole, but does not need to detail precise requirements for specific health entities. The iGPS would also not be a natural home for administrative or practical requirements for entities that are not closely related to Government priorities.

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A targeted approach will allow the iGPS to focus on its main objective – setting Government's policy priorities and expectations – without the risk of dilution.

11. Should you agree with this approach, it is helpful to then consider the circumstances in which additional direction-setting content may be included in the iGPS. In our view, to make the case for inclusion – whether in the core iGPS or as an appendix – the following should be met:

    a. that the information supports the statutory intent and purpose of the GPS;

    b. that the information is essential to understand the priorities and expectations of the iGPS (i.e. there is risk of misinterpretation if this is not provided); and

    c. that the information requires the legal status of the GPS (i.e. that health entities must give effect to it), for instance because this cannot be drawn from other legislative provisions.

12. To inform our assessment of the above criteria, we have considered the statutory requirements for the GPS in the Pae Ora legislation. Although we believe these are largely met by the current draft iGPS [HR20220840 refers], in our view there is one area where statutory requirements are not yet fully evident:

    a. Section 43C(1)(e) of the Pae Ora Bill requires the GPS to include 'a framework for regular monitoring of progress and reporting requirements', including a summary of metrics against which iGPS performance will be measured. We have provided you with advice on specific metrics for monitoring the iGPS, but this is not currently included in the iGPS in full.

13. We have considered the above in relation to existing documents, and potential new content that has been identified during the iGPS development. Our assessment and recommendations are set out below.

## Assessment of potential iGPS appendices

14. We have considered the case for a number of potential documents and materials to be incorporated in the iGPS. In each, we have reviewed the intended purpose of the document, and the fit with the criteria above. Headlines are provided below; further detail of our assessment of the core documents is attached at Annex A.

*Monitoring and reporting framework*

15. **We recommend that the monitoring and reporting framework be included in the iGPS.** This provides important definition of how Government priorities are to be measured and tracked over time, and indicates the basis for how success will be assessed. It also meets the statutory requirement for the GPS as noted above. Further description on the proposed approach is provided below.

*Service Coverage Schedule*

16. **We recommend that the SCS be maintained as a Ministerially-mandated set of minimum service coverage expectations, but is not included in the iGPS.** The SCS sets national minimum expectations for service coverage, and forms a clear baseline for the commissioning and provision of health services. Although the SCS is not monitored specifically, is an integral element of Ministers' requirements for the

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health system, and therefore should continue to be part of the health system. However, it does not align well with the iGPS as a vehicle for policy priorities and expectations, and moreover requires further review and likely reform in the short term. Further advice on this element is provided below.

*Operational Policy Framework*

17. **We recommend that the OPF is retained as guidance for health entities, but is not included in the iGPS.** The OPF consolidates numerous existing statutory requirements, such as those derived from the Public Service Act 2020, Crown Entities Act 2004 and the Public Finance Act 1989. The OPF is currently endorsed by the Minister but does not – and nor does it need to – have a statutory basis in its own right, and it does not create any new requirements on health entities. It is intended to draw together a range of rules and expectations into a single framework to provide clarity. We believe there remains benefit in such clarity for new health entities, in particular as the Pae Ora Bill will replace or supersede some existing practical requirements.

18. However, the nature of the detail in the OPF is not well aligned to the purpose of the iGPS. The OPF includes practical day-to-day and business rules, of the type which should be expected to be embedded in system processes and relationships and endure over time. The iGPS, by contrast, sets Government's policy priorities and expectations for a shorter period. Including the OPF in the iGPS may suggest that these practical requirements could change more regularly.

19. We propose that the OPF be updated and published by the Ministry, so that it is available for health entities from July 2022. Communication of the practical requirements to entities could also be supported by other steps including Board and entity leadership induction. However, this would be separate to the iGPS and would not form part of the policy priorities or associated monitoring framework.

*Other existing direction-setting documents*

20. In relation to other direction-setting documents and related mechanisms:

    a. **We recommend that the use of Ministerial letters of expectation to set strategic direction for Health NZ and the Māori Health Authority of the type included in the GPS should be reduced, with the aim that these are not used routinely for this purpose.** This is in line with previous Cabinet advice and would avoid the risk of confusion or competing priorities with the GPS.

    Letters of expectation may continue to be necessary to convey expectations that are particular to individual entities and cannot be captured in the iGPS (including for health entities other than Health NZ and the Māori Health Authority, whose full functions may not be reflected in the GPS), and to clarify your expectations for the annual monitoring programme – the Ministry will provide you with advice on this separately next week. Any such use of letters should be closely aligned with the GPS of the day. There may in particular be a case for the use of letters of expectation for all health entities (including Health NZ and the Māori Health Authority) in the first year from July 2022, given the interim nature of the iGPS and the emerging structures and plans for the reformed system. The Ministry will advise on this in due course.

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Letters of expectation may also still be used from time-to-time as an intervention measure (e.g. to set specific requirements for an entity in response to an identified issue).

b. **The existing Eligibility Direction will be transferred under the Pae Ora legislation and will continue.** We do not believe there is a rationale for including this in the iGPS since it has a clear statutory basis of its own and, similarly to the OPF, is a more enduring mechanism.

c. **Existing health strategies will also be transferred under the Pae Ora legislation, until such a time as new strategies are made.** Such strategies serve a different purpose to the iGPS, and we do not believe they should be explicitly included (although cross-references may be made in some places to provide context). You will receive separate advice shortly on the approach to developing new health strategies.

d. Powers for Crown funding agreements are not retained in the Pae Ora legislation and will no longer be an explicit option. However, equivalent powers to set requirements on funding for entities are contained within the Minister's powers to set the GPS and approve the NZ Health Plan, and therefore will support consolidation of these requirements into the new accountability and direction-setting mechanisms. The Ministry will provide you with further advice on steps, and documentation required, to support funding transfers from the Ministry to the new health entities from Day 1.

*Other potential documents*

21. The Ministry of Health and the Transition Unit have identified a number of other categories of document that could be incorporated in the iGPS. These include documents which:

a. summarise agencies' planned approach to delivering other Government initiatives not included in the substantive iGPS; and

b. set out other elements of the overall accountability framework or administrative requirements, such as an interventions escalation framework and data and information reporting requirements.

22. We do not recommend including any of these documents in the iGPS. We consider them relatively poorly aligned to the statutory purpose of the GPS, as they neither set priorities, nor parameters for the development of the NZ Health Plan. Where there is a case for providing clarity for health entities on an intended approach (e.g. the approach to the use of intervention powers), this can be achieved through other means including presentation to entities' leadership and separate publication, if necessary.

## Monitoring framework and metrics

*Including a monitoring framework and metrics as an appendix would promote transparency, and align to Pae Ora Bill requirements for the full GPS.*

23. The Ministry has provided you and the Minister of Finance with advice on intended Day 1 monitoring settings, including for the iGPS [HR 20220858 refers].

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24. As noted above, the Pae Ora Bill requires that a monitoring framework be included in the first full GPS you issue. The same rationale that underpins inclusion of this requirement in the Bill for the full GPS applies to the iGPS: inclusion of a monitoring framework will ensure public and cross-agency transparency by making expectations for system performance clear, and will reduce the risk of people having different views on how the iGPS should be delivered, or what good looks like.

25. We therefore recommend that you include the planned monitoring framework for the iGPS as an appendix to the document. The Pae Ora Bill does not specify what a monitoring framework has to look like; so we recommend that the framework for inclusion in the iGPS be based on that described in the advice to you and the Minister of Finance on the proposed arrangements for Day 1 monitoring. We expect that this will in particular highlight the specific metrics which are included in each of the iGPS chapters, and provide necessary definitions for these.

26. We would expect further levels of detail as to how the Ministry and other agencies will monitor entity and system performance to underpin the summary in the iGPS. However, we recommend against including such detail in the iGPS, to avoid tying agencies to a detailed monitoring approach from Day 1: a measure of healthy change and evolution in monitoring should be expected as the reformed system and its monitoring settings mature.

27. Subject to your agreement, the Ministry will work with the Transition Unit and Treasury to outline the monitoring framework to be included as an iGPS annex. Health NZ and the Māori Health Authority will be consulted and provide comment on the scope of this monitoring framework before it is provided to you for approval, alongside the final iGPS.

## Minimum service expectations

*We recommend maintaining service coverage requirements to set clear parameters for the development of the New Zealand Health Plan.*

28. A major aspiration of the reforms has been to improve consistency in the quality of healthcare across New Zealand, combatting the postcode lottery, while still allowing for tailoring of care to meet local needs. To achieve this, Health NZ and the Māori Health Authority will develop an approach to commissioning and delivering services nationally, regionally and locally to strike the appropriate balance between national consistency and local flexibility.

29. An intended feature of the system operating model will be that Health NZ and the Māori Health Authority can generally determine the right level at which services are planned, commissioned and managed. This flexibility will be needed to realise the benefits of reforms, by making better use of the resources we have available today. However, there will always be some aspects of service provision which Ministers will want to specify or mandate, to ensure a minimum level of service coverage, and will not want these levels to be changed without Ministerial agreement, such as:

    a. the minimum range and availability of publicly-funded services which New Zealanders would expect to have available regardless of circumstances – such as the range of services that are provided by primary health care providers;

    b. services which are specifically funded through Budget processes or which are specified through Government policy commitments;

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c. setting the costs for accessing the most fundamental health services – for example, requiring that emergency care is provided free, and fixing the cost of prescriptions for pharmaceuticals; and

d. determining entitlements in certain circumstances, usually where national certainty is desirable to protect specific communities (e.g. the accessibility of IVF treatment) or where particular communities would be adversely effected if entitlements were to be changed.

30. There are a range of service coverage requirements which have been agreed by you and Cabinet, or previous Ministers, which remain mandatory features of the health system as a result. While these requirements are generally already mandated in their own right, if they are not aggregated in any one place it is difficult for Health NZ and the Māori Health Authority to have full visibility of mandatory policy settings.

31. To date, the Service Coverage Schedule (SCS) has been the mechanism used in the current system to set out the minimum range of services Government expects to be publicly funded for eligible people. All DHBs are required to ensure the minimum range of services are made available to their populations; though in some instances DHBs have deviated from the SCS, and the SCS explicitly permits (or requires) district-by-district variations to entitlements in some cases.

32. Because we consider there will always be some aspects of service policy which you and successive Ministers of Health will want to fix, and because we have a number of live and 'legacy' policy commitments to specific service offerings, we recommend refining the existing SCS into a more focused set of Minimum Service Coverage Expectations (MSCE) for the system. This should continue to be a Ministerially-mandated document, which is agreed by (and any changes approved by) the Minister of Health, and published by the Ministry. This will provide clear parameters for the development of the New Zealand Health Plan and support transparency during the first two years of the reform, as health entities are establishing themselves.

33. However, we do not believe that is it necessary for this detail to be formally incorporated into the iGPS framework:

a. the nature of the service coverage expectations is detailed and technical, and in places not well aligned to the narrative and priorities of the iGPS. There is a risk of confusing the key iGPS messages if presented as part of the same framework;

b. the expectations themselves may be more liable to change during the multi-year period of a GPS, for instance as new policies are agreed to extend services, or as new service models are developed. More formal attachment to the iGPS could hinder flexibility for in-year changes;

c. the individual service coverage elements have their own mandate from Ministerial decisions, and do not need to rely on the statutory authority of the iGPS to have effect; and

d. as below, there is a need for a detailed review of the current SCS which may lead to substantive changes, and therefore risk from presenting the version for Day 1 as being final or too deeply embedded in the new arrangements.

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34. We propose that the iGPS make reference to the MSCE, to be clear on its continued existence and status. But this would not be an attempt to bring the MSCE within the iGPS framework, for the reasons above.

35. Should you wish to take a broader approach to the iGPS that seeks to incorporate more direction-setting content, the MSCE could be included more clearly in the iGPS (alongside other materials). You may also wish to review the case for the explicit inclusion of the MSCE in the three-year GPS to follow from July 2024, once further work has been undertaken to update the document. However, in our view it is not necessary to incorporate it at this stage.

*Today's Service Coverage Schedule requires further review*

36. The current SCS is a hybrid of many government policies regarding access, higher-level expectations, and more detailed service specifications. In some respects, it does not fit clearly with the reformed health system, where there is intended to be a clearer line between government policy requirements (as reflected in the GPS) and operational service planning and delivery expectations (through the NZ Health Plan and other specifications developed by Health NZ and the Māori Health Authority).

37. The Ministry has already made considerable progress in simplifying today's SCS, removing some specifications and operational detail about the service coverage expectations, and refining it into a more focused MSCE document. However, Health NZ and the Māori Health Authority have indicated that they would prefer a higher-level approach to service coverage specification which leaves more room for them to commission certain services differently to today. Such a high-level approach is aligned to the intent of reforms, but needs to be handled carefully to avoid unintended consequences.

38. We are conscious of the short window between now and the publication of the iGPS. Any changes could have significant policy, financial and presentational implications – not least in the perception that services are being taken out of the national minimum. We therefore propose a pragmatic approach to Day 1 which seeks to preserve the existing approach in the initial MSCE document, but acknowledges and creates space for further development.

39. The Ministry will provide you with separate advice on the proposed content for the Minimum Service Coverage Expectations for Day 1. This will set out the changes from the existing SCS and seek your agreement to publish the document.

40. Beyond this Day 1 version, **we further recommend that the Ministry of Health work with Health NZ and the Māori Health Authority to more fully review the initial MSCE and identify areas where further reform or simplification is possible.** We expect that this review will consider any policy settings which are mandatory today – likely because of legacy Ministerial or Cabinet decisions – but which may no longer be fit for purpose. We also anticipate it will consider other areas where more considered Ministerial decisions will be needed on the appropriate degree of specification of services, and the impact of any change.

41. A more detailed review of the initial MSCE will take time to ensure that all potential policy and presentation implications are well understood. It will also need to consider how and when to implement any agreed changes (e.g. whether in-year, with possible consequences for the iGPS and iNZHP, or at the start of a new year or planning cycle).

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Furthermore, the review should consider the appropriate process for proposing any future changes to the MSCE on an ongoing basis, so that these can be raised by any health entity and considered properly by the Minister.

42. The Ministry will provide you with further advice on how to proceed with this review.

## Consultation

43. The Transition Unit and the Ministry of Health have consulted with interim Health NZ and the interim Māori Health Authority to develop this advice.

## Next steps

44. Subject to your agreement, agencies will work to rapidly finalise the detail of the appendices proposed, for inclusion in the near-final full draft of the iGPS for your review in early June.

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Document 5A

# Annex A

## Assessment of direction-setting documents

| Item | Description | Purpose | Assessment against Pae Ora Bill requirements | Relevance to reformed system | Risk of not including |
|---|---|---|---|---|---|
| Measures for the interim iGPS | The iGPS measures comprise a small set of key marker measures for each iGPS priority area, focused on the desired system changes.<br><br>The measures identified in the iGPS form one component of the wider system monitoring framework that will include system monitoring entity monitoring and tracking delivery of the interim New Zealand Health Plan. | The iGPS measures support delivery of the iGPS priorities and outcomes by identifying the key marker measures used to track progress for the system establishment period.<br><br>The measures and their definitions will be made publicly available by the Ministry of Health. | b) how the Government expects health entities to meet the Government's priorities and objectives for the health system<br><br>g) a framework for regular monitoring of progress and reporting requirements. | The iGPS measures will evolve from the interim set as the system shifts are embedded and the GPS and Health Plan move to a steady state from July 2024.<br><br>Inclusion of detailed measure definitions in the iGPS supports transparency information for health system commissioning agencies, providers, health system users and all New Zealanders. | Inclusion of measure definitions for key marker measures in the iGPS ensures there is transparency and clarity of expectations about the way delivery of the iGPS will be measured and monitored. This may lead to a focus on the way progress is measures rather than the progress itself. |
| Interim Core Service Coverage document | Service coverage expectations set out the minimum range of services Government expects to be publicly funded for eligible people, expressed at a population level. Service coverage expectations also identify patient charges the | Service coverage expectations provide information for health services funders, providers users and all New Zealanders. | a) how the Government expects health entities to meet the Government's priorities and | Minimum service coverage expectations have been a core part of the Crown's expectations for the health system since the 1990s. | If service coverage expectations are not included in the iGPS, and are not otherwise presented and communicated, there is no clear mechanism for |

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| Item | Description | Purpose | Assessment against Pae Ora Bill requirements | Relevance to reformed system | Risk of not including |
|---|---|---|---|---|---|
| | circumstances where a patient charges can be applied in the system as agreed by Government policy.<br><br>Service coverage service expectations **do not:**<br>• set expectations about the quantum of services to be delivered to meet population needs<br>• specify how and where services are delivered<br>• specify the mix of services<br>• create individual level entitlements. | Service coverage expectations are updated as often as required to reflect Ministerial or Cabinet decision (for example, a recent addition to the requirements was an expectation that the full range of publicly funded health and disability services are available for all people evacuated from Afghanistan).<br><br>Service coverage expectations are made publicly available by the Ministry of Health. | objectives for the health system | Setting national minimum expectations remains a feature of the system until Ministers determine to delegate this authority to health entities. This has not been advised to date. | setting high-level minimum Government expectations about the range of publicly funded services. This could lead to cuts in the range of publicly funded services available for the population or adjustments to patient charges being without Ministerial agreement. |
| Interim Operational Policy document | The operational policy document summarises mandatory health system business rules and operational policy that have been agreed by Cabinet or through ministerial decisions and legislation so that these expectations are transparent and easily accessible. | Providing a consolidated view of Cabinet and Ministerially agreed decisions about the system operational policy environment means both existing and new decisions are transparent to health system commissioning agencies, providers, health system users and all New Zealanders. | a) how the Government expects health entities to meet the Government's priorities and objectives for the health system | The operational policy document has been a core part of the Crown's expectations for the health system since the 1990s.<br><br>Operational and administrative requirements remain important for health entities, and the underlying statutory | If operational policy expectations are not included in the iGPS it may be difficult for health system entities, providers, users and the public to be aware of and have easy access to the full range of Government's system level operational policy |

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| Item | Description | Purpose | Assessment against Pae Ora Bill requirements | Relevance to reformed system | Risk of not including |
|---|---|---|---|---|---|
| | | Transparency about the operating environment is particularly important during the system transition period to support stability as entities are being established.<br><br>Operational policy expectations are updated as often as required to reflect new government decisions. (For example system monitoring responsibilities for assisted dying services were a recent inclusion in the operational policy expectations).<br><br>Operational policy expectations are made publicly available by the Ministry of Health. | | basis for most requirements has not changed (e.g. Public Finance Act). | requirements for the health system resulting in process gaps for key government processes.<br><br>However, this can be mitigated if these requirements are sufficiently visible through another route. |

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Document 6

MINISTRY OF HEALTH
MANATŪ HAUORA

# Briefing

## Update on the interim Government Policy Statement (iGPS) – final draft iGPS and steps to completion

| **Date due to MO:** | 10 June 2022 | **Action required by:** | 14 June 2022 |
|---|---|---|---|
| **Security level:** | IN CONFIDENCE | **Health Report number:** | 20220972 |
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Copy to:** | Hon Peeni Henare, Associate Minister of Health | | |

## Contact for telephone discussion

| Name | Position | Telephone |
|---|---|---|
| **Dr Ashley Bloomfield** | Director-General of Health | s 9(2)(a) |
| **Stephen McKernan** | Director, Transition Unit | s 9(2)(a) |

## Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

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# Update on the interim Government Policy Statement (iGPS) – final draft iGPS and steps to completion

| **Security level:** | IN CONFIDENCE | **Date:** | 10 June 2022 |
|---|---|---|---|
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Copy to:** | Hon Peeni Henare, Associate Minister of Health | | |

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## Purpose of report

1. This report provides you with an update on the development of the interim Government Policy Statement (iGPS). It includes:
   a. a final draft of the iGPS with an updated 'basket' of measures for each priority chapter (Annex 1);
   b. an additional table to support your decision-making on the iGPS measures which sets out the original proposed measures, a summary of feedback from the interim Māori Health Authority (iMHA) and interim Health NZ (iHNZ), and the recommended final measures (Annex 2);
   c. the 'health sector accountability and monitoring framework' technical appendix (Annex 3).
2. This report also includes feedback on the iGPS narrative and iGPS measures from the iMHA, iHNZ, Treasury, and other health Crown entities; how we have responded to that feedback; and the steps to complete the iGPS.
3. This report seeks:
   a. your feedback on the final draft iGPS package, as listed above;
   b. your agreement to take the final draft iGPS package to the Ministerial Oversight Group for Health and Disability System Reform for approval in mid-June, ahead of publication before 1 July.
4. This report discloses all relevant information and implications.

## Summary

5. We have continued to refine the draft iGPS narrative. Health Crown entities and the Treasury have provided a range of useful suggestions and feedback which we have considered carefully and adopted, where it has improved the content and consistency of the document, in line with your priorities and expectations. As discussed, we have sought to avoid unnecessary detail and keep the narrative

document focussed on what is most important in the first two years of the reformed health system.

6. Through engagement with iMHA and iHNZ, we have developed a refined set of iGPS measures. The total number of proposed measures is now 30, including two newly proposed measures from the Transition Unit. The table in Annex 2 includes a column for you to agree or disagree to each measure.

7. You have previously agreed to include the 'health sector accountability and monitoring framework' in the iGPS as a technical appendix. We recommend that the draft high-level content in Annex 3 be incorporated to provide this information. This provides an important definition of how Government priorities are to be measured and tracked over time and indicates the basis for how success will be assessed.

8. We will provide the 'data definitions' technical appendix following your approval of the iGPS measures; we do not believe that this detail is necessary for inclusion in the version of the iGPS to be shared with Ministerial colleagues, but you will want to approve it before it is finalised.

9. Now that the iGPS is nearly complete, we seek your feedback on the iGPS package as a whole. Subject to your feedback and agreement, the Ministry will finalise the iGPS and provide a cover paper so you can take the iGPS to the Ministerial Oversight Group for approval via email in the week of 13-17 June 2022.

10. Please note the iGPS has not yet been professionally proof-read. Initial layout and design are underway. We seek your confirmation that you want the document to reflect Government (rather than Ministry) branding.

11. We also seek your indication as to whether you want to table the iGPS in the House of Representatives as soon as reasonably practical after issuing it to relevant health entities. This is considered good practice but is not essential for the interim GPS under the Pae Ora legislation.

12. As a next step, we are working with the Māori Health Authority to determine respective roles and responsibilities in the health sector accountability framework described in Annex 3.

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## Recommendations

| We recommend you: | | |
|---|---|---|
| a) | **Note** this is the final draft interim Government Policy Statement (iGPS) for your review and feedback before it goes to the Ministerial Oversight Group Health and Disability System Reform for approval. | |
| b) | **Note** the iGPS in Annex 1 incorporates feedback from the interim Māori Health Authority (iMHA), interim Health NZ (iHNZ), Treasury, and other health Crown entities. | |
| c) | **Provide feedback** on the iGPS in Annex 1. | **Yes / No** |

| d) | **Note** the assumption that the mental health and addiction ring-fence will continue in the coming two years, and that the iGPS has been revised accordingly to make this explicit. | |
|---|---|---|
| e) | **Note** that we have developed a refined set of iGPS measures through engagement with iMHA and iHNZ and there are two newly proposed measures from the Transition Unit (paragraphs 21-23) | |
| f) | **Agree** to either:<br><br>Include the two newly proposed measures now, prior to them being socialised with iMHA and iHNZ<br><br>Or;<br><br>Ask officials to do further work on the newly proposed measures and report back to you. | **Yes / No**<br><br>**Yes / No** |
| g) | **Approve** the measures to be included in the final iGPS (Annex 2). | **Yes / No** |
| h) | **Approve** the 'health sector accountability and monitoring framework' technical appendix (Annex 3) | **Yes / No** |
| i) | **Note** that the Ministry will provide you with the 'data definitions' technical appendix following your approval of the iGPS measures. | |
| j) | **Agree** subject to any necessary changes, to take the iGPS to the Ministerial Oversight Group for final approval in the week of 13-17 June 2022. | **Yes / No** |
| k) | **Indicate** whether you want to table the iGPS in the House of Representatives as soon as practical after issuing it to relevant health entities. | **Yes / No** |
| l) | **Confirm** that Government branding will feature on the published iGPS and technical appendices, not Ministry branding. | **Yes / No** |
| m) | **Note** that the Ministry and Transition Unit will continue to work with iHNZ and iMHA to ensure the priorities in the iGPS cascade into the interim NZ Health Plan as intended. | |

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Maree Roberts
**Deputy Director-General, System Strategy & Policy**
Date:

Pp:
Stephen McKernan
**Director, Transition Unit**
Date: 13/05/2022

Hon Andrew Little
**Minister of Health**
Date:

# Update on the interim Government Policy Statement (iGPS) – final draft iGPS and steps to completion

## Context

1. On 13 May 2022 we provided you with the third narrative version of the iGPS and our initial advice on iGPS measures [HR 20220840 refers]. Your office indicated that you were broadly comfortable with the proposed measures but queried whether one of the measures for Māori health should be an increase in the number of enrolled patients (since that is more likely to represent a real improvement in equity of access). We have addressed this query in paragraphs 30-31 below.

2. Following separate advice from us on the iGPS technical appendices on 27 May 2022 [HR 20220936 refers], you decided on a targeted approach, to ensure the iGPS remains focused on the high-level priorities and expectations for the health system.

3. We shared the draft iGPS and proposed iGPS measures with the interim Māori Health Authority (iMHA), interim Health NZ (iHNZ), Treasury, and other health Crown entities, and in response to their feedback have refined the iGPS language and content as described below. Following meetings with a joint working group of the iMHA and iHNZ boards and their officials, we have developed final advice on the iGPS measures.

## Further feedback on the draft iGPS and how we have responded

4. The iMHA and iHNZ boards and officials noted that the iGPS has come a long way. They had very little additional feedback on the narrative and focused mostly on the proposed measures, reported in paragraphs 19-29 below.

5. Treasury's feedback centred on how Budget 22 decisions are reflected in the document and wording refinements in relation to resourcing and financial sustainability.

6. The key feedback from other health Crown entities is as follows:

7. The **Health Quality and Safety Commission** (HQSC) recommended broadening the existing six priority areas to include a focus on the health system becoming more consumer and whānau-centred, and strengthening governance and leadership for health quality and safety.

8. To achieve this, rather than expanding the existing six priority areas, we have reframed one objective and accompanying actions, and added another into priority 2 (which focuses on laying the foundations for the reformed system):
    a. objective 2.3: build the system around the voices of people and whānau
    b. objective 2.5: strengthen governance and leadership for quality, safety and equity.

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9. The **Health and Disability Commissioner** (HDC) suggested three priority areas should be more visible in the iGPS: older people; women's health; and home care and community support services. HDC has concerns about the capacity and capability of current home care and community support services to deliver care to a vulnerable population and the associated lack of transparency over the care provided. They recommend a comprehensive monitoring framework to oversee the quality and safety of the system.

10. We have given the HDC feedback careful consideration. To maintain the readability of the narrative document, we have not made changes to specifically identify older people and women as priority groups. This is because the priorities and objectives are intentionally framed broadly to refer to people without seeking to name all the different groups that are of interest in different contexts. In relation to the monitoring of home and community support services, this suggestion is picked up by the new quality and safety objectives mentioned in paragraph 8 above.

11. The **Mental Health and Wellbeing Commission** welcomed the emphasis on the socio-economic determinants of health and wellbeing given their significant contribution to health outcomes. The Commission recommended a stronger focus on mental health and wellbeing throughout the document and adding reference to a broader range of communities, i.e. *people who share a common identity, experience, or stage in life that increases the risk that they will experience poor mental health and wellbeing.*

12. We have strengthened the iGPS in the areas suggested by the Commission, however have not adopted the suggested wording to refer to a broader range of communities. We currently reference Māori, Pacific peoples, disabled peoples including tāngata whaikaha Māori, LGBTQI+ communities, Asian peoples, refugee and migrant communities and people with lived experience of mental health and addiction issues.

13. **Pharmac** offered broad support on the draft iGPS.

14. In addition to the changes outlined above, the Ministry (including the interim Public Health Agency) and the Transition Unit have made wording refinements throughout the iGPS narrative.

15. In summary we have made the following changes to the iGPS since the last version (13 May 2022):

    a. Added Budget 22 references where appropriate throughout the document.

    b. Strengthened references to:

        i. mental health and addiction (also note the point in paragraph 16 below regarding the ring-fence);

        ii. population and public health;

        iii. the determinants of health;

        iv. prevention of illness and promotion of health and wellbeing;

        v. disability, including improving access and moving beyond equitable participation to equitable outcomes.

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c. Aligned references to Te Tiriti o Waitangi with the health system principles in the Pae Ora Bill, based on advice from Crown Law.

d. Added new objectives on strengthening the voices of people and whānau, and governance and leadership for quality, safety and equity, in priority 2.

e. Removed explicit references to carers, as the whānau-centric approach of the iGPS encompasses carers.

16. We have also revised the reference to investment in mental health and addiction services (in priority 6, objective 3) to ensure that the wording is consistent with maintaining the mental health and addiction ring-fence. This has been included explicitly within the published 2022 Vote Health Estimates measures, and therefore our assumption is that the ring-fence will be retained on the same basis for the next two years. While previous versions of the iGPS implied that the ringfence would continue, we consider it important to be explicit about this expectation. We should be grateful for your confirmation of this point.

17. This revision will support the proposed objective that annual investment in mental health and addiction increases, at a minimum in line with cost and demographic pressures. Officials across the Ministry and new health entities will work together to set ringfence expectations for this two-year period, while also progressing work to enhance future funding mechanisms to protect mental health and addiction investment.

18. This aligns with your agreement to progress the recommendations from the Office of the Auditor General's recent review of the ring-fence to improve guidance and the funding methodology [HR20220518 refers]. s 9(2)(f)(iv)

## Updated iGPS measures following iMHA and iHNZ feedback

19. As noted in our report of 13 May 2022, the draft iGPS measures were at an early stage of development and required refinement in partnership with iMHA and iHNZ boards and officials. This work is now complete and we seek your approval of the final measures for inclusion in the iGPS.

20. The measures continue to be situated within each priority chapter of the iGPS, and as a summary table at the end of the iGPS (Annex 1). To support your decision-making, we have also provided an additional table (Annex 2) which sets out the original measures, a summary of feedback from iMHA and iHNZ, and the proposed final measures, with a column for you to agree or disagree to each measure. The total number of proposed measures is now 30 and you might want to reduce these further.

21. The Transition Unit proposes two new measures for inclusion. The first focuses on presentations to emergency departments or after-hours for non-accidental presentations that could have been resolved in a primary care setting. The intent is to use this measure as a proxy of unmet need within primary care settings. This would be noted as a developmental measure as the data definition and collection methodology are worked through.

22. The second newly proposed measure seeks to capture the proportion of overall spend on governance, non-clinical administration and management costs. While

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initially the quality of the data may make this challenging, this measure can help ensure the focus is on the front line and there is not a build-up of overhead costs.

23. We note that these measures have not yet been widely socialised with iHNZ and have not been discussed with iMHA, and may require further development and revisions pending consultation with the new entities before they are added into the set.

*General comments on measures*

24. Broadly, the iMHA and iHNZ had two key pieces of feedback on the approach to the measures:

    a. Both indicated they would favour a smaller number of measures (around 10-15), with a focus on outcomes that reflect the intended system shifts. There was a suggestion that some measures may be more suitable for inclusion in the interim NZ Health Plan (iNZHP) and therefore not placed within the iGPS.

    b. Both were keen to ensure that measures were reasonable for where change may be expected in the next two years, so that they are able to showcase success.

25. On the first of these, we agree that the iGPS measures should provide an overview of progress, tied to the system shifts and Government's priorities. We have considered the case for revising, combining or dropping individual measures that do not add value to one or more of the baskets, and make a number of proposals for change.

26. However, reducing the overall number of measures further, or trying to reach an arbitrary total number, will not necessarily improve how these function collectively. The "right" number is that which provides sufficient coverage for your priorities, and which enables the effective analysis of data in baskets. Indeed, we are concerned that a small number (e.g. 10 measures) would naturally draw more focus onto those which have been chosen, potentially creating perverse incentives.

27. We also do not think that there must be a clear distinction between measures in the iGPS and iNZHP. While there will be different level of detail between the iGPS and iNZHP in general terms, there will be benefit in some measures being included in both: this reinforces a focus on the area and supports a clear line of sight between the documents and how they are monitored. The measures may be used differently for the iGPS (where it will be part of a basket supporting overall analysis of progress with objectives by the Ministry) as compared to the iNZHP (where it may be used for performance management by entities), but this is not a reason for separation.

28. On the second point above, we agree and have considered this in making proposals. Our view is that all measures should be capable of demonstrating progress over the next two years, and the iGPS will include a clear performance expectation for each. Any specific considerations on this in relation to individual measures are noted in the table in Annex 2.

*Specific comments on measures*

29. Following is a summary of the key issues and changes to the basket of measures in each priority chapter.

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a. **Chapter 1 - Embedding Te Tiriti o Waitangi across the health system**: No significant change, with only proposed refinement of wording in relation to Māori health providers. We note that MHA intends to undertake work to strengthen measures in this area, for example to define te ao Māori health services that may inform future GPS measures.

b. **Chapter 2 - Laying the foundations for the ongoing success of the health system**: We propose to add a measure on consumer engagement in assessing health services, using an existing framework from HQSC, and remove the measure reporting on public engagement on strategic documents such as the interim NZ Health Plan. This change aligns with HQSC feedback that the voices of people and whānau should be strengthened in the iGPS.

c. **Chapter 3 - Keeping people well in their communities**: Nine measures were proposed for this priority. This has been reduced to seven by combining two that focus on the same issue, but for age-specific groups, and by removing the measure on the number of days spent in hospital in unplanned care. The focus of the removed measure is partly addressed through another measure on acute re-admissions.

d. We propose to keep the measure of people waiting for planned specialist care who receive it within four months. iHNZ raised limitations with the fixed period wait time, and also noted that measures of access to treatment, already included, were more important. We consider that timeliness in responding to health needs remains a strong public expectation.

e. **Chapter 4 - Achieving equity in health outcomes**: We recommend combining the two measures relating to missed appointments. iHNZ and iMHA are concerned this measure on missed appointments is a compliance measure that does not drive behaviours that generate results. While we agree that broader access measures are more important, measures of missed appointments highlight a range of issues in the system, which include access, service delivery meeting people's needs or people's trust in or willingness to use services. This can be reconsidered when improved measures of access and take-up of services are developed in the future.

f. Regarding the measure 'Reduction in differences between Māori and non-Māori in wait times between screening and treatment for breast, cervical and bowel cancer services', we agree with iHNZ's proposal to shift to conversion rates from identification of cancer to start of treatment, from the previous proposed cancer wait-time based measure. We also recommend that this measure be expanded to all ethnicities.

g. There is a new proposed measure, related to unmet primary care need, as outlined in paragraph 21.

h. **Chapter 5 - Developing the health workforce of the future**: We propose keeping a measure based on a staff engagement survey, but have identified this as a developing measure. iHNZ has indicated that significant work is needed to complete the Health Charter as a prerequisite for a staff engagement survey. They also consider a survey will have significant cost.

i. We propose keeping, but slightly adjusting, a health workforce pipeline measure of increasing diversity of graduates from health training programmes.

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Given health training programmes are multi-year this will not shift in the short-term, however, it is signal of the future direction and where the health sector and Ministry need to undertake actions to meet future workforce needs.

j. We have proposed combining two sets of measures related to the ethnic make-up of the health workforce and leadership in health entities. The appropriate demographic breakdowns can be provided within the same measure.

k. **Chapter 6 - Ensuring a financially sustainable health system**: There is a new proposed measure related to a lower share of expenditure being spent on the administration of the system, enabling more to be spent on frontline workforce and frontline health services, outlined in paragraph 22.

l. The health entities noted the complexity of developing a productivity measure and we have emphasised that the Ministry and the Treasury will work with the health entities on this.

30. Regarding your query as to whether one of the measures for Māori health should be 'an increase in the number of enrolled patients', we note that this is captured in the iGPS measure about 'unmet need for primary care' (as collected in the New Zealand Health Survey), as well as downstream indicators around ASH rates.

31. Further, the new proposed measure of people accessing emergency department or after hours, when it could have been resolved in primary care, is also a proxy measure for unmet primary care, and would also capture issues with access to primary care including from those un-enrolled. While enrolment percentages are included in the wider monitoring set, there are significant issues with deciding the appropriate baseline population (due to differences in ethnicity identification between PHO data and Stats NZ data).

## The iGPS technical appendices

32. Your decision to take a targeted approach means that the iGPS will have three technical appendices:

   a. the 'health sector accountability and monitoring framework' appendix (Annex 3);

   b. the 'iGPS measures' appendix, which will list the agreed measures in one table with some supporting narrative; and

   c. the 'data definitions' appendix, which provide the technical details for the iGPS measures. This will be provided to you for approval, following your approval of the measures.

33. The health sector accountability and monitoring framework appendix will summarise how the health system will be held to account, and how performance will be monitored and reported over time. This will provide context for the role of the iGPS and the specific iGPS measures.

34. As noted previously, the Pae Ora Bill does not specify what an accountability or monitoring framework has to look like. We recommend that the framework for inclusion in the iGPS be based on that described in the recent advice to you and the Minister of Finance on the proposed arrangements for Day One monitoring [HR 20220858 refers].

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35. In particular, we propose that the framework that is set out in the iGPS is high-level and aims to give an overview of the approach but not describe processes in detail. This will ensure that it provides context for the iGPS and some clarity on how key accountability arrangements will be managed, but will preserve space for technical details to be confirmed subsequently (e.g. the wider range of indicators and reporting templates, on which joint Ministers will receive further advice later this month). This information can be posted on the Ministry's website in due course.

36. Similarly, in the body of the iGPS we have referred to a separate Minimum Service Coverage Expectations document that will be available online for 1 July 2022. This is not part of the iGPS itself, but part of a broader suite of key system documents published to ensure clarity for Day 1.

## iGPS alignment with interim NZ Health Plan (iNZHP)

37. We are continuing to work with iHNZ and iMHA to ensure the priorities and expectations within the iGPS cascade as intended into the iNZHP, and the Ministry has provided high-level comments on an early draft version of the iNZHP.

38. We understand budget reconciliations of priority actions in the iNZHP are now underway and metrics will need to be tested for alignment with the iGPS measures when these are finalised. The Transition Unit and Ministry will review the metrics to ensure that these provide confidence that the iNZHP is deliverable within budget and provide appropriate assurance for Budget 22 cost pressure contingency draw down.

## Steps to complete the iGPS

39. Subject to your final review and feedback, we will finalise content and prepare a cover paper for you to take the iGPS to the Ministerial Oversight Group (MOG) for approval via email in the week of 13-17 June 2022. This will include a full legal review of the iGPS to ensure alignment with the requirements of the Pae Ora legislation.

40. At the same time, we will have the iGPS professionally proof-read. Further, we will complete the lay-out and design of the document following your confirmation that the iGPS should reflect Government branding, but not Ministry branding.

41. On 21 June 2022 we will provide a briefing with the iGPS technical appendix on data definitions for your approval. We do not consider that this technical appendix needs to be approved by the MOG.

42. We expect to provide you with the final, designed iGPS ready for approval to publish on 24 June 2022. Publication would then be expected in the final week of June, which could be aligned with announcement of the permanent boards of HNZ and the MHA.

43. From there, the only requirement is for you to issue the iGPS to relevant health entities, which can be done via email. However, as soon as practical after being issued to entities, you may wish to table the iGPS in the House of Representatives. This is only a requirement for a full GPS, not an interim one, but is considered good practice. We welcome your decision on this, so we can sequence this into the final timeline.

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s 9(2)(h)

## Next steps

45. We are working in partnership with the Māori Health Authority to determine respective roles and responsibilities in the health sector accountability framework described in Annex 3.

46. Over the next two years we will work with you to develop the strategies in the Pae Ora legislation which will provide the strategic framing for the next GPS.

**Annexes**

Annex 1: Final draft interim Government Policy Statement

Annex 2: Summary of updates to iGPS measures

Annex 3: 'Health sector accountability and monitoring framework' technical appendix

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## Annex 1: Final draft interim Government Policy Statement

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## Annex 2: Summary of updates to iGPS measures

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# Annex 3: Health sector accountability and monitoring framework technical appendix

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## Annex 2: Summary of updates to iGPS measures

| | Specific iGPS measures for priority area | Status update following engagement with iMHA and iHNZ | Previous measure, if change | Minister feedback Yes / No |
|---|---|---|---|---|
| **1.** | **Embedding Te Tiriti o Waitangi across the health system** | | | |
| 1.1 | Health entity spending on Māori health service providers | Modified to make clear is all Māori health providers, not only kaupapa Māori providers | Funding received by kaupapa Māori health service providers | |
| 1.2 | Experience of health services for Māori as measured by the primary health care and adult inpatient patient experience surveys | No change | | |
| 1.3 | Geographical coverage and utilisation of rongoā Māori service | No change, but further work with MHA to develop future measures to help set standards for commissioning and co-commissioning and/or build metrics that can be used more broadly than rongoā Māori services, including new kaupapa services that will be developed | | |
| 1.4 | Feedback from the Iwi Māori Partnership Boards on how they are fulfilling their role and whether they are receiving the support they require | No change, but note this measure involves the Ministry of Health developing a new survey, informed by the boards' functions and work with MHA | | |
| **2.** | **Laying the foundations for the ongoing success of the health system** | | | |
| 2.1 | Health entities are clear about their own and other entities' roles and responsibilities, and are delivering to these | No change.<br>This will be a monitor's assessment, informed by discussion with entities – to include a maturity and activity assessment by domain to be completed by June 2024.<br>Entities suggested a more specific focus, for example an assessment of completing documents such as iGPS and Health Plan in a collaborative manner.<br>The Ministry and Transition Unit view is that a broad focus on demonstrating that roles and responsibilities are being fulfilled as intended, is key to monitoring the successful implementation of reforms. We will work to develop approach with entities. The process of developing this measure with stakeholders will give an indication of progress with system changes | | |
| 2.2 | Experience of primary health care and adult inpatient health services measured across demographic groups using patient experience surveys | No change | | |
| 2.3 | Proportion of entities, or service units within, who have been assessed against the Consumer Engagement Quality and Safety Marker; and of those, the proportion who have been assessed at Level 3 or 4 | We propose that this measure be amended to focus on public/consumer engagement as a means of responding to community feedback and increasing public confidence.<br>This measure may require another revision to wording, pending further consultation with HQSC | Feedback from public engagement on public accountability processes such as Health Plan. HNZ and the MHA will publish a feedback report similar to the latest Hui Whakaoranga report | |
| 2.4 | Proportion of medical appointments completed through digital channels (initially outpatients and expanding to include GP appointments when data is available) | Propose measure broadens coverage from outpatient appointments to medical appointments, to also cover GP appointments, as suggested by iHNZ.<br>This measure will also be disaggregated by ethnicity to ensure equity of this approach, as suggested by iMHA. | Proportion of appropriate outpatient appointments completed through digital channels | |
| **3.** | **Keeping people well in their communities** | | | |
| 3.1 | Proportion of people reporting unmet need for primary health care, reported by ethnicity and geographic area | No change | | |
| 3.2 | Proportion of people waiting for planned specialist care who receive it within four months, reported by ethnicity and geographic area | No change. iHNZ raised limitations with fixed period wait time, and also that measures of access to treatment, already included, were more important. Propose keeping measure as timeliness in responding to health needs is still a strong public expectation | | |
| Removed | Number of days spent in hospital for unplanned care including emergencies reported by ethnicity and geographic area | Broad agreement that this measure is removed, as supports an overall reduction of measures in this priority area. This measure will continue as a Health Sector Indicator. | | |
| 3.3 | Uptake of immunisations for key age groups, reported by ethnicity and geographic area | No change | | |
| 3.4 | Rate of hospital admissions for an illness that might have been prevented or better managed in the community, reported by key age groups | Broadened measure to include other age groups, so it can combine with the measure focussed on adult age groups below | Rate of hospital admissions for children under five for an illness that might have been prevented or better managed in the community | |
| Removed | Rate of hospital admissions for people aged 45 to 64 for an illness that might have been prevented or better managed in the community | Proposing to remove as combined with measure 3.4 | | |
| 3.5 | 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 | No change | | |
| 3.6 | Enrolment with a primary maternity care provider in the first trimester of pregnancy, reported by ethnicity and geographic area | Modified proposed measure to reflect different service models for primary maternity services | Enrolment with an LMC in the first trimester of pregnancy by ethnicity | |
| 3.7 | Standardised rate of acute readmissions within 28 days of discharge, reported by ethnicity and geographic area | No change, but note this measure is a proxy measure that can identify a range of issues, including impact of primary and community services in preventing admissions, and success of hospital treatment | | |
| **4.** | **Achieving equity in health outcomes** | | | |
| 4.1 | Variation of clinical prioritisation for cancer treatment and elective surgery, reported by ethnicity and geographic area | No change, but note further work may propose better measurement options in future. Clinical prioritisation is the implementation of a national process for fairness in assessments to access treatment.<br>iHNZ and iMHA noted they prefer measure on access of people receiving care not prioritisation, and on reducing variation by population and locality. This needs to be developed | | |

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| Specific iGPS measures for priority area | | Status update following engagement with iMHA and iHNZ | Previous measure, if change | Minister feedback Yes / No |
|---|---|---|---|---|
| 4.2 | Proportion of people who start first treatment for breast, cervical and bowel cancer after a screen result (presence of cancer), reported by ethnicity and geographic area | Changed proposed measure, following discussion with health entities, to focus on conversion rate from screening with cancer identified to treatment entry for breast, cervical and bowel cancer.<br>This measure has also shifted from Embedding Te Tiriti to Equity in health outcomes priority, as focus on equity for outcome, and expanded the measure to cover all ethnicity differences | Reduction in differences between Māori and non-Māori in wait times between screening and treatment for breast, cervical and bowel cancer services | |
| 4.3 | 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 | No change, but note further work may propose better measurement options in future<br>iHNZ and iMHA have recommended a focus on people receiving care equitably rather than reducing variation | | |
| 4.4 | Missed appointments for specialist care, reported by ethnicity and geographic area | No change. Could revise in future with improved access-focussed measures. Also combined with measure below as this measure is broad and can cover Māori, Pacific and other ethnic groups.<br>iHNZ and iMHA concerned that this is a compliance measure that does not drive behaviours that generate results | | |
| Removed | Reduction in the proportion of Did Not Attends for Maori and Pacific Peoples compared to non-Maori / non-Pacific, paired with standardised rate of FSAs / Follow-ups. | Propose removing as combined into measure 4.4 | | |
| 4.5 | Rate of diabetes complications, reported by ethnicity and geographic area | No change<br>A Budget 2022 initiative focussed on improving diabetes outcomes for the Pacific community in Auckland. This measure can also include trends for this specific population group within breakdowns | | |
| 4.6 (New) | *New proposed measure:* Attendance at emergency departments or after-hours for non-accidental presentations that could have been resolved in a primary care setting, reported by ethnicity and geographic area (measure in development) | A new measure is proposed for equity in health outcomes. This proposed measure is a proxy for unmet need for primary health care, with analysis of differences between demographic groups. This measure will be in development, with further discussion on approach with the health entities | | |
| **5.** | **Developing the health workforce of the future** | | | |
| 5.1 | Engagement survey of staff on culture and shift towards one team ethos (measure will be in development as work to build data collection) | Propose revising to reflect that this measure will be in development. It will be informed by the Health Charter, and also take time to develop the data collection. iHNZ considers the new data collection will have significant additional costs. If measure agreed to and the survey is developed, iMHA identify cultural safety as an important component and the Ministry and the Transition Unit identify professional development as an important component | Engagement survey of staff on culture and shift towards one team ethos (health charter to inform this) | |
| 5.2 | Proportion of Māori and other under-represented groups in the regulated and unregulated health workforce, compared to the demographics of the total population | Propose modified measure to combine two workforce measures. Measure will now include both Māori and other under-represented demographic groups in health workforce. Focus will be on regulated workforce across whole health sector. However, the measure will also include some workforce data from the unregulated health workforce employed by HNZ | Percentage of Māori in the regulated workforce compared with the percentage of Māori in the population | |
| Removed | Proportion of other demographic groups in the regulated workforce compared with the proportion in the population (measured from data from the Professional Councils) | Propose removing as combined into the measure 5.2 | | |
| 5.3 | Number and proportion of graduates of health training programmes from demographic groups under-represented in health workforce, compared to the demographics of the total population | Propose revised measure to focus on pipeline of graduates coming into the workforce. Noted, entity feedback that in short-term limited ability to influence for graduates as training takes multiple years. However, this signals a key change needed for the system. Whole health sector, including Ministry, are responsible for shifting this in future | Increase in number and diversity of enrolees entering training programmes to become a registered health professional (including rural training) | |
| 5.4 | Proportion of Māori and Pacific people in leadership and governance roles across the Ministry of Health and health entities | Propose modified measure to apply to health entities, as defined in Pae Ora Bill (HNZ, HQSC, MHA, Pharmac, or NZBOS). Consistent with expectations on these Crown entities around health principles and government strategies | Number and percentage of Māori in leadership and governance roles across the Ministry and health sector Crown entities | |
| Removed | Number and proportion of Pacific people in leadership and governance roles across the Ministry and health sector Crown entities | Propose removing as combined into the measure 5.4 | | |
| **6.** | **Ensuring a financially sustainable health system** | | | |
| 6.1 | Actual expenditure is consistent with budgeted and, overall budgeted and actual expenditure balances | No change | | |
| 6.2 | Quality-adjusted, system-level productivity | No change - note that we will develop this measure with health entities and the Treasury | | |
| 6.3 | Proportion of total expenditure on mental health and addiction, public health, and primary and community care increases over time, across all entities in the system | No change, but note could be time-series and over time needs to develop to include all community care, i.e. NGO, community teams. This measure can monitor expectations around the mental health and addiction ringfence | | |
| 6.4 | Planned maintenance and capital expenditure are delivered, including delivery of an Asset Management and Capital Capability Plan | No change | | |
| 6.5 (New) | *New proposed measure:* Proportion of overall spend on governance, non-clinical administration and management costs | This new measure is proposed to support one of the objectives of the health reforms, a lower proportion of expenditure on the administration of the system to enable increased proportion of expenditure on the frontline workforce and health services. This measure will be in development | | |

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# Annex 3: 'Health sector accountability and monitoring framework' technical appendix

## Health sector accountability framework

1. Both the Ministry of Health and the Māori Health Authority have statutory monitoring roles in the reformed health system and work in partnership to develop and embed the health sector accountability framework.

2. The Ministry has a strengthened role as chief steward and MHA with new statutory functions to: monitor the delivery of hauora Māori services by Health New Zealand and provide public reports on the results of that monitoring; monitor, in co-operation with the Ministry and Te Puni Kōkiri, the performance of the publicly funded health sector in relation to hauora Māori; and evaluate the delivery and performance of services provided or funded by the Māori Health Authority.

3. Improving accountability arrangements to lift health sector performance and better manage risk is a key goal of the health reforms. To support changes over time, Ministers have agreed a high-level design for an accountability framework for the future health system.

4. As outlined in the diagram in Figure 1 below, the health sector accountability framework has four key elements:

   a. *Direction-setting*: how priorities, expectations and requirements are set, including through the Government Policy Statement.

   b. *Planning*: how health entities translate expectations and requirements into substantive plans for delivering health services and their other functions. This will include the New Zealand Health Plan, other service plans, and entities' own business plans.

   c. *Monitoring and reporting*: how we assure progress towards system goals, identify risks, and monitor progress on agreed plans, including the role of entities themselves and their boards, and the role of system monitors and Ministers.

   d. *Intervention*: what happens if monitoring highlights risks, issues or opportunities for improvement at any level of the health sector.

5. This framework ensures that there is a comprehensive picture of how the health sector is performing over time, is clear on respective roles, and ensures health entities are held appropriately to account for their responsibilities.

6. The focus of monitoring and reporting is on three areas outlined further below: outcomes, priority actions and operational performance.

## Outcomes

7. The ultimate focus of how the health sector performs for New Zealanders should be on the outcomes achieved. These outcomes should be the end results which matter most to people – like improved quality and length of life, improved population health and strengthened communities. They will also include system outcomes that are key

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elements of the Government's reforms, such as reducing variation and inequity, shifting care into communities, and optimising the use of resources.

8. These types of outcomes help set a clear direction for all parts of the health sector, recognising that entities will make different contributions towards them. While many of these outcomes will move only slowly over time, it's important that we monitor them to ensure we're moving in the right direction.

9. The Ministry of Health will publish a health sector outcomes framework to outline the shared expectations of Ministers, New Zealanders and health agencies for the performance of the health system overall. This outcomes framework will both help focus monitoring from July 2022 on the areas which matter most, and indicate where we expect to see improvements over time - including through planned investments. The outcomes framework will be reviewed and updated as part of the development of the next New Zealand Health Strategy.

## Priority actions

10. In addition to monitoring outcomes, there are a range of priorities where we would expect to see actions completed and milestones achieved over time, because these will all contribute to our desired outcomes. These will include actions indicated by the interim GPS, health strategies, the interim NZ Health Plan, Budget 22 investments, and other priority initiatives (such as the Access and Choice programme). They will also incorporate the necessary activities to implement and refine the new structures, functions and ways of working as part of the Government's health reforms.

11. The Ministry of Health, the Māori Health Authority and other system monitors will monitor progress against these priorities and milestones to ensure the system is making sufficient progress. The monitoring of priority actions will assist in identifying areas where further support or investment might be needed, or where there are emerging barriers to achieving planned activities. This will often provide us with faster feedback than outcomes, and can assure sustained progress.

## Operational performance

12. Alongside outcomes and priorities, the monitoring of overall operational performance of health entities will ensure that the mechanics of the health system continue to operate well. Monitoring operational performance brings together indicators from across the health sector, including from the New Zealand Health Plan, Statements of Intent, Vote Health and Service Performance Expectations, Health System Indicators, and other measures (such as those used by the Health Quality and Safety Commission).

13. Indicators will be reported in targeted ways to provide an overall view of performance at monthly, quarterly, annual, or biannual periods; and at national, regional and district levels as appropriate. Much of the day-to-day reporting on these measures will be led by Health NZ, with the Ministry of Health and the Māori Health Authority retaining a role in interpreting these to provide insights on overall system performance.

## How we will monitor and report

14. All health entities will be expected to report on progress against their objectives and the Government's expected outcomes and priorities on a regular basis. Monthly and

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quarterly reports will support routine monitoring of entities' performance at an appropriate level of detail, supported by statutory annual reports. These reports will include the outcomes, priorities and operational performance areas of focus noted above.

15. Health entities will develop their own reporting for their boards and internal governance arrangements; and these will be shared with the Ministry of Health in its role as the lead monitor for the health sector. Specific expectations for reporting include:

## Entity-level reporting

a. Focused on service-level and organisational activity on a monthly basis, including using quarterly and annual checkpoints to check the value added by activity delivered through public funding.

b. This will include reporting against the New Zealand Health Plan and the entity's Statement of Intent and Statement of Performance Expectations to outline progress against Government's agreed goals and health reforms – both through formal reporting avenues, and more regular, informal reporting to Ministers.

## Sector-level reporting

a. Focused on delivery of outcomes and priorities across the whole-sector, including monitoring of progress on the interim GPS and health strategies. Quarterly reporting by the Ministry of Health will draw on entity reports and provide additional insights, including deep dives into identified areas of risk or opportunity.

b. These reports will support the Minister to provide quarterly reports to Cabinet on progress with the reforms, and identify any issues for discussion or action which can then be taken forward through the regular engagement with the entities. They will also inform statutory annual progress reports.

16. Regular reports will be made publicly available to share progress against health sector goals, for both individual entities and the system as a whole, and will be audited by the Auditor-General where relevant.

17. Over time, this reporting will also include the routine publication of national data to the public and other stakeholders, so that there is transparency of key information. It will also be supplemented by the publication of annual reports for each locality on progress against their locality plans (in line with the requirements of the Pae Ora (Healthy Futures) Act.

18. In the short-term, reporting will rely on the data available today, and on measures which are currently used to evaluate entity and system performance (e.g. Health System Indicators). These will be progressively expanded through to 2023/24 to provide a more comprehensive picture of entity and system performance over time, once new data can be identified and collected, and new measures are adopted. Progress will be measured against agreed baselines and expected goals, so that real and expected progress can always be compared.

19. Wherever possible, indicators will be disaggregated for reporting by demographic characteristics including age, ethnicity, gender, geographic location as appropriate, and as data sources allow.

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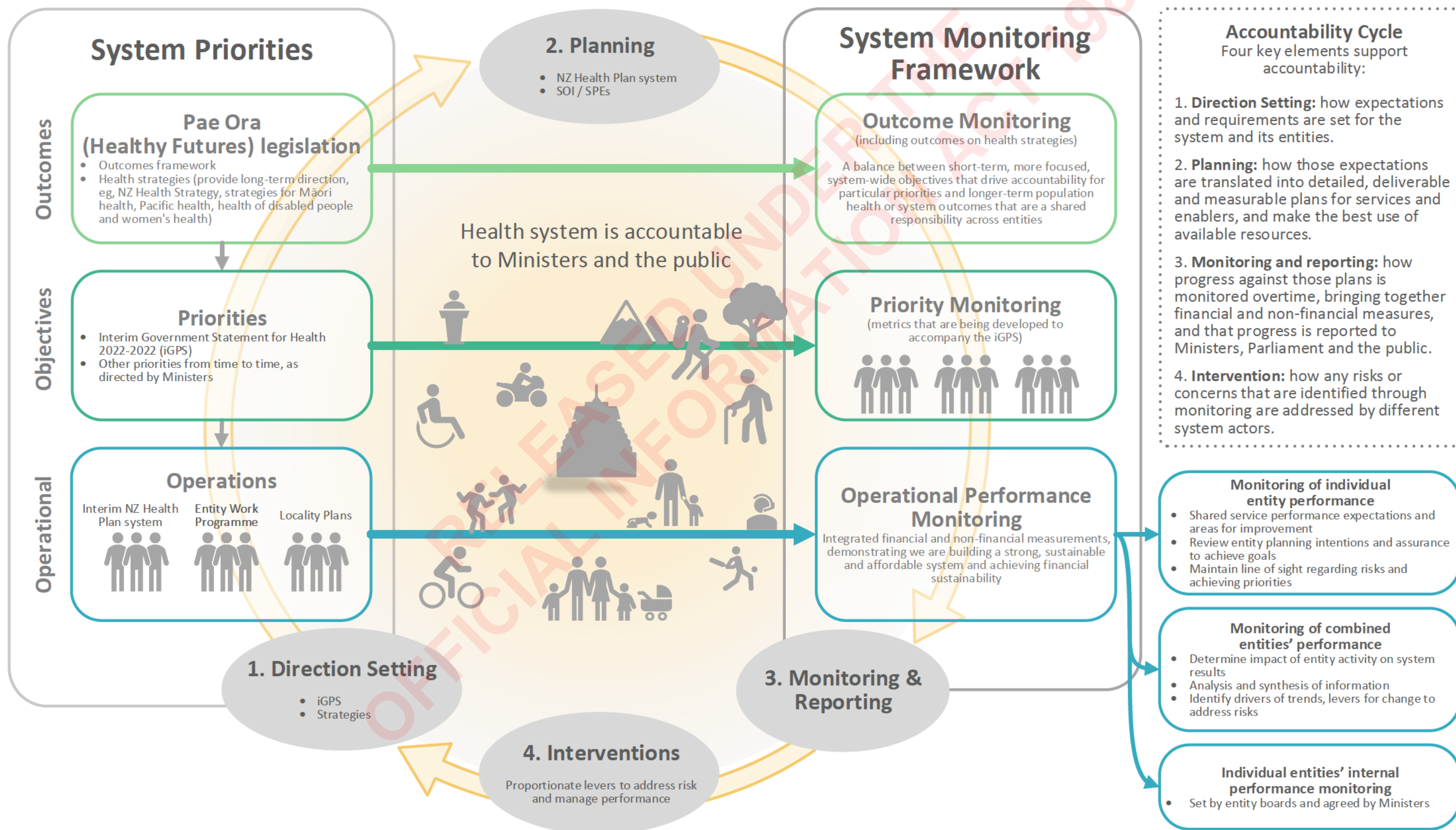
# Health Sector Accountability Framework

MINISTRY OF HEALTH
MANATŪ HAUORA

The health system reforms include establishing an approach to **system-wide planning and accountability** that is **coherent, reflects system priorities** and **outcomes,** and **links long-term strategic direction** with **service and capacity planning**. This approach will be **multi-yea**r and will directly connect **budgets** with **organisational actions**. A **high-level design** that comprises a number of different functions **working in alignment**.

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# Briefing

## Interim Government Policy Statement for Ministerial Oversight Group on Health and Disability System Reform

| **Date due to MO:** | 16 June 2022 | **Action required by:** | 17 June 2022 |
|---|---|---|---|
| **Security level:** | IN CONFIDENCE | **Health Report number:** | 20221051 |
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Copy to:** | Hon Peeni Henare, Associate Minister of Health | | |

## Contact for telephone discussion

| Name | Position | Telephone |
|---|---|---|
| **Dr Ashley Bloomfield** | Director-General of Health | s 9(2)(a) |
| **Stephen McKernan** | Director, Transition Unit | s 9(2)(a) |

## Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

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# Interim Government Policy Statement (iGPS) for Ministerial Oversight Group on Health and Disability System Reform

| | | | |
|---|---|---|---|
| **Security level:** | IN CONFIDENCE | **Date:** | 16 June 2022 |
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Copy to:** | Hon Peeni Henare, Associate Minister of Health | | |

## Purpose of report

1. This report provides you with an attached briefing to the Ministerial Oversight Group on Health and Disability System Reform, seeking their approval in principle to issue the interim Government Policy Statement on Health. We are seeking your agreement to forward the attached briefing to your Ministerial colleagues.

## Recommendations

We recommend you:

a) **Note** that we have incorporated your feedback on the interim Government Policy Statement on Health, including the set of measures.

b) **Note** that to reflect your decision, we have removed the two new measures proposed, so that further work can be done before a final set of measures is provided to you on 23 June 2022.

c) **Note** that the attached briefing for the Ministerial Oversight Group on Health and Disability System Reform seeks their feedback and approval in principle for the interim Government Policy Statement to be issued.

d) **Note** the attached briefing seeks the Ministerial Oversight Group's authorisation for you to approve the final design, the final technical appendices including the measures, and any further minor and technical changes and additions prior to its publication.

e) **Note** the third technical appendix on data definitions is not attached in the briefing. As it is minor and technical, it does not require approval from the Ministerial Oversight Group. We plan to provide this to you for approval on 21 June 2022.

f) **Note** if you have feedback on the attached interim Government Policy Statement briefing for your Ministerial colleagues, we will work with your office to update the briefing before being provided to the Ministerial Oversight Group on Health and Disability System Reform on Friday 17 June 2022.

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g) **Agree to forward** the attached briefing to the Ministerial Oversight Group on Health and Disability System Reform seeking their feedback and approval to issue the interim Government Policy Statement on Health. **Yes / No**

h) **Note** that to meet the publication date on or before 1 July 2022 for the interim Government Policy Statement, we will need receive approval in principal from your Ministerial colleagues by 21 June 2022, and your final approval by 27 June 2022.

Dr Ashley Bloomfield
**Director-General of Health**
Date: 16/06/2022

pp:

Stephen McKernan

**Director, Transition Unit**
Date:

Hon Andrew Little
**Minister of Health**
Date:

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# Interim Government Policy Statement for Ministerial Oversight Group on Health and Disability System Reform

## Background

1. On 10 June 2022 we provided you, for feedback and approval, an interim Government Policy Statement (GPS) on Health including the measures for each of the six priorities [HR20220972 refers].

2. This report outlined that after your feedback, we would seek approval to issue the interim GPS from the Ministerial Oversight Group on Health and Disability System Reform. You outlined this intention for the interim GPS to be approved by this ministerial group in the May 2022 Cabinet paper on progress with the health reforms [SWC-22-MIN-0089]. The Ministers in this group, in addition to yourself and Associate Health Minister Hon Peeni Henare, are: Rt Hon Jacinda Ardern, Prime Minister; Hon Grant Robertson, Minister of Finance; and Hon Poto Williams, Minister of Disability Issues.

3. On 15 June 2022, we received your final feedback on the iGPS, including its measures and the technical appendix on the 'health sector accountability and monitoring framework', which has been addressed as outlined below.

## Addressing your feedback on interim GPS

4. In the workforce chapter, we have sought to clarify the commitment to work on innovative approaches to clinical credentialing and qualification, including the ranges of scope for different roles and level of qualification required for every role.

5. While the interim GPS cannot direct changes to scopes of practice or level of qualification for clinical workforces (as these are set by Responsible Authorities under the Health Practitioners Competence Assurance Act 2003), we strengthened the existing objectives in chapter 5 to clarify our expectation that health entities will work with relevant stakeholders towards more flexible pathways for training and education, including to explore opportunities for clinical credentialing and qualification.

6. As per your direction, we have not included the two proposed new measures (4.6 and 6.5 – see below), so that further work can be completed over the coming week, including testing these with the new health entities and addressing your concerns about proposed measure 6.5 not creating an undue funding constraint on appropriate levels of administration support that frees up the clinical front line. Further advice on their these two proposed measures will be provided next week.

**Two proposed new measures – not included and subject to further work**

| |
|---|
| *Proposed as 4.6 (Equity):* Attendance at emergency departments or after-hours for non-accidental presentations that could have been resolved in a primary care setting, reported by ethnicity and geographic area (measure in development) |
| *Proposed as 6.5 (financial sustainability):* Proportion of total spend on frontline health workforces, compared to governance, management and administration support roles |

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*Other minor changes to the interim GPS measures*

7. For priority 6, Ensuring a financially sustainable health system, we have made a minor change to a measure on capital and asset management requirements, measure 6.4 (see below). This update reflects an agreed approach on this financial measure with the Treasury and the Transition Unit.

**Updated measure on financial sustainability – capital and asset management**

| *Updated measure 6.4*: Develop an Investment Strategy and National Asset Management Strategy by December 2023 |
|---|
| *Previous measure 6.4*: Planned maintenance and capital expenditure are delivered, including delivery of an Asset Management and Capital Capability Plan |

## Interim Government Policy Statement briefing for the Ministerial Group

8. The briefing outlines the purpose of the GPS and how it fits within the Government's direction-setting and accountability framework for the health system. It also explains why there is an interim GPS and that over 2022–2024 it will reinforce system shifts expected in the reformed health system. The briefing also references how Cabinet noted that the interim GPS would seek approval from the Ministerial Oversight Group on Health and Disability System Reform.

9. The briefing also outlines:
   - six key priorities of the interim GPS;
   - how these priorities align with Cabinet agreed priority outcomes and system shifts for the reformed health system;
   - engagement in developing the interim GPS;
   - what information on each key priority is covered in the interim GPS, such as why the priority is included and how it supports embedding Te Tiriti;
   - measures that will monitor progress towards the priorities;
   - wider monitoring and accountability framework for health system.

10. Attached to the briefing is also the full interim GPS, including the current 28 measures, and the accountability framework. The attachment for your Ministerial colleagues does not include the forthcoming data definitions appendix (to be provided to you 21 June), which will have more technical details on each measure. As this is very technical, this level of technical detail does not need to be approved by the Ministerial Oversight Group on Health and Disability System Reform.

11. We outline to your Ministerial colleagues in the briefing that full final set of measures, including their technical data definitions, are still being finalised for the Minister of Health. We also seek authorisation from the Ministerial Oversight Group on Health and Disability System Reform for you to agree to the final versions for publication, that include further changes to the technical appendices.

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*We will work with your office to update the briefing on the interim GPS to reflect your feedback*

12. If you have feedback on the attached briefing for the Ministerial Oversight Group on Health and Disability System Reform, we will work with your office to update the briefing to reflect this, prior to this being provided to your Ministerial colleagues on Friday 17 June 2022.

## Next Steps

13. We are working towards publication of the interim Government Policy Statement on Health on or before the 1 July 2022. Decisions needed to meet that publication date are:

    a. Ministerial Oversight Group on Health and Disability System Reform to provide any feedback, approval in principle to issue the interim GPS, and authorising the Minister of Health to make final minor changes before publication (by 21 June 2022);

    b. Final version of the interim GPS technical appendix on 'data definitions' approved by you (report to be provided on 21 June 2022);

    c. Final designed version of the interim GPS that has been prepared for publication is approved by you by 27 June 2022 (report to be provided on 23 June 2022).

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DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

MINISTRY OF HEALTH
MANATŪ HAUORA

# Briefing

## Interim Government Policy Statement on Health

| | | | |
|---|---|---|---|
| **Date due to MOG:** | 17 June 2022 | **Action required by:** | 21 June 2022 |
| **Security level:** | IN CONFIDENCE | **Health Report number:** | 20221070 |
| **To:** | Ministerial Oversight Group on Health and Disability System Reform | | |

## Contact for telephone discussion

| Name | Position | Telephone |
|---|---|---|
| **Dr Ashley Bloomfield** | Director-General of Health | s 9(2)(a) |
| **Stephen McKernan** | Director, Transition Unit | s 9(2)(a) |

## Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

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# Interim Government Policy Statement on Health

| **Security level:** | IN CONFIDENCE | **Date:** | 16 June 2022 |
| --- | --- | --- | --- |
| **To:** | Ministerial Oversight Group on Health and Disability System Reform | | |

## Purpose of report

1. This report provides an overview of the interim Government Policy Statement, attached as Annex 1, and seeks your feedback and approval to issue the interim Government Policy Statement on Health.

## Summary

2. The Government Policy Statement (GPS) on Health is part of the new accountability framework for the health sector set out in the Pae Ora (Healthy Futures) Act 2022 (Pae Ora Act). The first GPS will be developed to take effect from 1 July 2024.

3. As outlined to Cabinet in May 2022, the Minister of Health intends to issue an interim GPS for the first two years of the reformed health sector. While this interim GPS will not be a GPS issued under the Pae Ora Act, it will set out Ministerial expectations on what should be achieved by the health sector from 1 July 2022 to 30 June 2024. These shorter-term actions provide the foundations for the longer-term direction for the reformed system.

4. Cabinet noted that the interim GPS will be approved by the Ministerial Oversight Group on Health and Disability System Reform, as it was in-line with priorities and system shifts for the reformed health system approved by Cabinet.

5. The proposed interim GPS has six priorities:
    1. Embedding Te Tiriti o Waitangi across the health sector.
    2. Laying the foundations for the ongoing success of the health sector.
    3. Keeping people well and independent in their communities.
    4. Achieving equity in health outcomes.
    5. Developing the health workforce of the future.
    6. Ensuring a financially sustainable health sector.

6. These six priorities will provide clear direction for the first two years and provide the parameters for the interim New Zealand Health Plan for the delivery of publicly funded health services.

7. The interim GPS includes 28 measures to monitor progress towards the six priorities. Many of the expected shifts will take time to improve overall health outcomes, but change on specific measures within the health system, such as equity of access to services and treatment can improve over a shorter term. The Ministry of Health will work

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with the Māori Health Authority on monitoring the interim GPS, as part of the broader accountability and monitoring and framework.

## Recommendations

We recommend you:

a) **Note** that the purpose of the Government Policy Statement on Health is to set the priorities for the publicly funded health system and clear parameters for the development of the New Zealand Health Plan.

b) **Note** that the first Government Policy Statement on Health will be issued by 1 July 2024, as required under the Pae Ora (Healthy Futures) Act 2022.

c) **Note** that in May 2022 Cabinet noted the Minister of Health's intention to issue an interim Government Policy Statement on Health, to be approved by the Ministerial Oversight Group on Health and Disability System Reform [SWC-22-MIN-0089].

d) **Note** the interim Government Policy Statement on Health outlines the government priorities from 2022–2024 and also sets the parameters for the forthcoming interim New Zealand Health Plan for delivering publicly funded health services over that period.

e) **Note** that the interim Government Policy Statement priorities align with priority outcomes for the reformed health system and expected system shifts [CAB-21-MIN-0092 refers].

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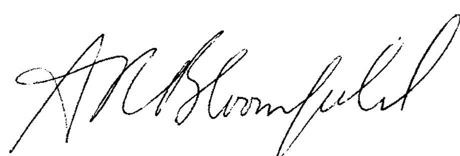
f) **Approve in principle** in the issuing of the interim Government Policy Statement on Health, attached as Annex 1. **Yes / No**

g) **Authorise** the Minister of Health to approve the final design, the final technical appendices including the measures, and any further minor and technical changes and additions to the interim Government Policy Statement on Health prior to its publication. **Yes / No**

h) **Note** that a final version of the interim Government Policy Statement will be provided to you prior to public release.

i) **Note** the Minister of Health intends to publicly release the interim Government Policy Statement on Health on or before 1 July 2022.



pp:

Dr Ashley Bloomfield
**Director-General of Health**

16/06/2022

Stephen McKernan
**Director, Health Transition Unit**

…../…../….

Rt Hon Jacinda Ardern
**Prime Minister**

…../…../….

Hon Grant Robertson
**Minister of Finance**

…../…../….

Hon Andrew Little
**Minister of Health**

…../…../….

Hon Poto Williams
**Minister for Disability Issues**

…../…../….

Hon Peeni Henare
**Associate Minister of Health**

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# Interim Government Policy Statement on Health

## Background

*Government Policy Statement sets priorities for health system*

1. Under the Pae Ora (Healthy Futures) Act 2022 (the Pae Ora Act) the Minister of Health will issue a Government Policy Statement (GPS) on health that will set expectations and system direction for a period of no more than three years.

2. The GPS is the means through which direction-setting, planning and budget funding cycles are aligned in the future system. The GPS sets the measures driving monitoring in the reformed system. Health entities[1] are required to give effect to the direction set in the GPS.

*GPS will inform operations and strategy*

3. The GPS is part of the reformed health system's accountability framework. The GPS sets the parameters for the New Zealand Health Plan to be developed jointly by Health New Zealand (HNZ) and the Māori Health Authority (MHA), that sets out the plan for delivering public funded health services over three years, aligning with three-year budget commitments for health.

4. The GPS must have regard to, but is not bound by, any health strategy. The Pae Ora Act requires that six health strategies be made as a minimum, although it is expected that Government will continue to set strategies in other areas over time, such as the planned rare disorders strategy in the Government response to the independent review of the Pharmaceutical Management Agency (Pharmac). The required strategies are:
   - New Zealand Health Strategy
   - Hauora Māori Strategy
   - Pacific Health Strategy
   - Health of Disabled People Strategy
   - Women's Health Strategy
   - Rural Health Strategy.

5. The health strategies include those for population groups that will be developed for the first time for disabled people, women and rural populations.

*The Interim GPS will set the Government priorities for the first two years*

6. The first two years of the health reforms from July 2022 will be a crucial transitional phase, in which new entities and structures will be developed and refined, and new functions and relationships embedded. It is expected that the health system will be operating close to a "steady state", in accordance with Cabinet's decisions on the future system model, from July 2024.

7. The Pae Ora Act requires that the first GPS be developed before 1 July 2024, two years after the Act comes into effect, to follow the end of this transitional phase and mirror the system moving to the steady state. The first GPS will also set the parameters for the first New Zealand Health Plan, and both will be developed to take effect from 1 July 2024. To

[1] Health New Zealand, Māori Health Authority, Health Quality and Safety Commission, Pharmaceutical Management Agency (Pharmac) and the New Zealand Blood and Organ Service.

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convey Ministerial expectations in the first two years, the Minister of Health intends to issue an interim GPS to reinforce the system shifts and priority outcomes expected of the reformed health system.

8. In May 2022, Cabinet noted that the interim GPS would be provided to the Ministerial Oversight Group on Health and Disability System Reform to approve, as it was in-line with objectives of the reforms already agreed to by Cabinet [SWC-22-MIN-0089].

9. The interim GPS is a public statement of what the Government expects the health sector to deliver and achieve in the first years of the health reforms, what funding and support is available, and how success will be measured and monitored.

10. The first two years mark the start of a journey to a reformed health system. While progress towards some goals will take a longer period, these early years will be critical to new the system being established, tested and refined, and new relationships and cultures fostered.

11. The interim GPS is a critical part of the accountability framework for directing and monitoring the desired system shifts in publicly funded health system from implementing the health reforms and the funding changes from Budget 2022. The interim GPS will also set the parameters for the interim New Zealand Health Plan, currently being developed by the interim HNZ and the interim MHA.

## Priorities in the interim GPS

*Priorities align with Pae Ora legislation and Cabinet objectives for the health reforms*

12. The proposed interim GPS has six priorities, which align with the health principles in the Pae Ora Act and priority outcomes for the health reforms agreed by Cabinet.

13. As a GPS intentionally reflects the strategic direction set by the Government of the day, this interim GPS was developed based on existing Cabinet decisions that set out the longer-term priority outcomes and system shifts expected of the reformed health system [CAB-21-MIN-0092 refers]. These priorities or system shifts reflected findings from the Health and Disability System Review and the Hauora report from the Waitangi Tribunal.

14. As this is a period of significant change within the health sector, the interim GPS deliberately translates those longer-term transformational priorities and system shifts into shorter-term achievable actions. This is to ensure good progress is made while the new entities and the broader sector adjust to new ways of working, and to ensure there is transparency and consistency around what is expected of the new system over the next two years.

15. Table 1 below illustrates how the interim GPS priorities reflect the longer-term priorities and five key system shifts expected of the reformed health system. The inclusion of the financial sustainability priority as an additional area within the interim GPS sets the Government's expectations for financial discipline and efficiency. It also relates to the linkages between the interim GPS and Budget 2022 Vote Health funding decisions, including the shift to multi-year health budgets.

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**Table 1: Interim Government Policy Statement priorities' alignment with Cabinet-approved outcomes and system shifts expected from the reformed health system**

| **Longer-term priority outcomes** (to achieve pae ora/healthy futures) | **Five key system shifts** (to achieve long-term outcomes) | **Priorities for 2022-2024** (contained in the interim GPS) |
|---|---|---|
| • Partnership: ensuring partnership with Māori in decisions at all levels of the system, and empowering consumers of care to design services which work for them | • The health system will uphold Te Tiriti principles and obligations and ensure equity for all | • Embedding Te Tiriti o Waitangi across the health sector |
| • Equity: tackling the gap in access and health outcomes between different populations and areas of New Zealand | • All people will have access to a comprehensive range of support in their local communities to help them stay well | • Laying the foundations for the ongoing success of the health sector |
| • Sustainability: embedding population health as the driver of preventing and reducing health need, and promoting efficient and effective care | • Everyone will have access to high-quality emergency or specialist care when they need it | • Keeping people well and independent in their communities |
| • Person and whānau-centred care: empowering all people to manage their own health and wellbeing, have meaningful control over the services they receive, and treating people, their carers and whānau as experts in care | • Digital services will provide more people with the care they need in their homes and communities and local communities | • Achieving equity in health outcomes |
| • Excellence: ensuring consistent, high-quality care in all areas, and harnessing innovation, digital and new technologies to continuously improve services | • Health and care workers will be valued and well-trained for the future health system | • Developing the health workforce of the future |
| | | • Ensuring a financially sustainable health sector |

*Content of the interim GPS*

16. Each of the six interim GPS priorities above are drafted into chapters that follow an intervention logic, which explains to the reader:

    a. why does this matter?

    b. outcomes we are working towards

    c. how this priority gives effect to Te Tiriti

    d. objectives for 2022–2024

    e. an outline of how we will measure progress through measures for each priority.

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17. The table below provides a summary of the priorities and objectives contained in each interim GPS chapter. Further below is detail on the measures that will be used to monitor progress over the next two years.

**Table 2: Interim Government Policy Statement: objectives the health system is moving towards, by key priority area**

| Key Priority | Objective moving towards |
|---|---|
| Embedding Te Tiriti o Waitangi across the health sector | • iwi, hapū, whānau and Māori communities can exercise their authority to improve their health and wellbeing.<br>• The health sector will meet its Te Tiriti obligations and progress towards achieving equitable health outcomes for Māori (including tāngata whaikaha Māori). |
| Laying the foundations for the ongoing success of the health sector | • The health sector and workers within it will demonstrate the values, principles, and behaviours as stated in the New Zealand Health Charter, at an organisational level, and individually.<br>• Health entities must become more responsive to consumers and whānau in the design, prioritisation and monitoring of services and initiatives. |
| Keeping people well and independent in their communities | • Improve equitable access to public, primary and community health services designed around the needs of people and their whanau.<br>• Health entities will undertake actions to address variation in access and health outcomes from emergency and specialist services over the next two years. |
| Achieving equity in health outcomes | • Health system that delivers high-quality health and wellbeing outcomes for all people and groups no matter where they live, what they have or who they are.<br>• Access to mainstream health services will be barrier-free and inclusive. |
| Developing the health workforce of the future | • The health workforce needs to be representative of the communities it serves, is fairer, and takes action to achieve equity in health outcomes.<br>• Create an environment where health is a career of choice. |
| Ensuring a financially sustainable health sector | • Prioritise investment to achieve the greatest value, making sure we not only invest in the right places but also that funding is invested well and achieves the results we want as efficiently as possible.<br>• Support financial sustainability, by reducing unnecessary duplication and making it easier to plan and implement arrangements supporting improved efficiency, effectiveness, and value for money. |

*Measures of the interim Government Policy Statement*

18. We are currently proposing 28 measures to monitor progress across the six priorities of the interim GPS. The full final set of measures, including their technical data definitions, are still being finalised for the Minister of Health. We propose that the Ministerial Oversight Group on Health and Disability System Reform authorise the Minister of Health to make changes to these technical areas prior to publication of the final interim GPS.

19. The measures for each priority are in their respective chapter and in a summary table (see page 38 of the interim GPS in Annex 1). These measures include: access to primary health care, equity in access to health treatment, amount of funding for Māori health care providers, increasing diversity in the health workforce, and that actual expenditure is consistent with budgeted and there is overall balance in both budgeted and actual revenue to expenditure ratios.

20. Most of the measures, where appropriate, will be able to be broken down to show differences between different population groups (including age, gender, ethnicity, geographic area or disability status), and will therefore also support monitoring of equity. Our aim is that all relevant measures will, in time, be able to be disaggregated for a wider range of appropriate groups, including disability.

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21. Monitoring the measures in the interim GPS is one of the processes that is part of the accountability framework for the health system. The Ministry of Health has a strengthened role as chief steward and MHA also has a statutory function to monitor health system outcomes.

22. Improving accountability and monitoring arrangements to lift health sector performance and better manage risk is a key goal of the health reforms. To support these changes an accountability framework for the future health system is part of the technical appendices of the interim GPS.

23. The Ministry of Health and MHA will work in partnership, and with the Treasury on financial monitoring, to develop and embed the health sector accountability framework.

**Engaging stakeholders on interim GPS**

*Engagement with health entities and other stakeholders*

24. The Ministry of Health and the Transition Unit have worked with the interim MHA, as a partner in monitoring the health system, on the development of the framing and focus of the interim GPS. This engagement led to further embedding Te Tiriti o Waitangi throughout the interim GPS.

25. Also, to ensure the priorities, objectives and measures contained in the interim GPS are transformative yet achievable in the first two years of the reformed health system, the Ministry of Health and the Transition Unit undertook consultation with interim MHA and interim HNZ. These two health entities have the main responsibility giving effect to the changes through their funding and delivery of health services. This engagement with them also informs their development of the interim New Zealand Health Plan for the delivery of public funded health services, that gives effect to the interim GPS.

26. A disability perspective has also been reflected through the report. The Ministry of Health's disability directorate, that will partly transition to the new Ministry for Disabled People, provided input into this as the Government's current lead advisor on disability policy.

27. The Ministry has also worked with the Treasury around the financial sustainability priority and related measures, and the Ministry will continue to work with them especially as the productivity measure is developed.

28. The priorities in the interim GPS have also been part of targeted engagements that socialise the system shifts and expected outcomes of the reforms with the health sector and community stakeholders. A series of webinars led by the Minister and health sector leaders attracted more than 1,200 participants across the sessions.

## Publication of the interim GPS

29. If you approve in principle the interim GPS, it will be published on or before 1 July 2022. This will provide clear direction to the public and health entities of the Government's priorities and expectations for the reformed health system from 1 July 2022.

*Minister of Health will approve the final interim GPS*

30. The Interim GPS includes technical appendices with measures, including their detailed technical definitions, and the accountability framework. These will have minor changes prior to publication, such as to the measures. We propose the Ministerial Oversight Group on Health and Disability System Reform authorise the Minister of Health to

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finalise the technical appendices, along with other technical or minor changes to the interim GPS prior to its publication.

*Interim New Zealand Health Plan*

31. Once the interim GPS is published, the next component of the accountability framework to support the health reforms is the interim New Zealand Health Plan. This plan is currently in development by the interim Health New Zealand and interim Māori Health Authority. After these agencies are formally established on 1 July 2022, they will complete the final plan, for approval by the Minister of Health.

32. The interim New Zealand Health Plan is expected to be published by the agencies in the first months following their establishment.

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# Annex 1: Interim Government Policy Statement

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# Briefing

## Final Interim Government Policy Statement (iGPS) package for approval to issue and publish

| **Date due to MO:** | 28 June 2022 | **Action required by:** | 30 June 2022 |
|---|---|---|---|
| **Security level:** | IN CONFIDENCE | **Health Report number:** | 20221112 |
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Copy to:** | Hon Peeni Henare, Associate Minister of Health | | |

## Contact for telephone discussion

| Name | Position | Telephone |
|---|---|---|
| **Dr Ashley Bloomfield** | Director-General of Health | s 9(2)(a) |
| **Stephen McKernan** | Director, Transition Unit | s 9(2)(a) |

## Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

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# Final Interim Government Policy Statement (iGPS) package for approval to issue and publish

| | | | |
|---|---|---|---|
| **Security level:** | IN CONFIDENCE | **Date:** | 28 June 2022 |
| **To:** | Hon Andrew Little, Minister of Health | | |
| **Copy to:** | Hon Peeni Henare, Associate Minister of Health | | |

## Purpose of report

1. This report provides you with the final version of the interim Government Policy Statement on Health (Annex 1), including the measures and technical appendices. It seeks your approval of the iGPS measure expectations that will be included in the technical appendix of the iGPS and includes the data definitions for the interim Government Policy Statement measures.
2. The report seeks your final approval to issue the interim Government Policy Statement to health entities and publish it on the Ministry of Health (the Ministry) website on or before Friday 1 July 2022.

## Recommendations

We recommend you:

| | | |
|---|---|---|
| a) | **Note** that we have incorporated final feedback on the interim Government Policy Statement on Health (iGPS), including feedback from the Ministerial Oversight Group on Health and Disability System Reform (highlighted in Annex 2), the interim Māori Health Authority and interim Health New Zealand. | |
| b) | **Note** the third technical appendix on 'data definitions' is included in the final iGPS (pages 49-68). | |
| c) | **Agree** the expectations included in the summary table on data definitions and baselines for the iGPS measures attached at Annex 6. | **Yes /No** |
| d) | **Note** that following further work on two newly proposed measures [HR 20220972 refers] including consultation with the interim health entities, we do not recommend these for inclusion in the iGPS. | |
| e) | **Approve** the attached iGPS (Annex 1) for issuing to health entities and publication on the Ministry website on or before 1 July 2022. | **Yes /No** |

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f) **Sign** the attached three letters (Annex 3) which issue the iGPS to the health entities required to give effect to Government policy; and letters to the two new entities (Annex 4) to be established on 1 July 2022, that will also be required to give effect to Government policy. Also attached are letters to the other entities in the wider health sector that may wish to align their work with the Government priorities (Annex 5).

g) **Note** that we are working with your office on any necessary communications material to support the publication of the iGPS.

h) **Note** in line with your previous agreement to table the final iGPS in the House of Representatives following it being issued to entities on or before 1 July 2022, we will work with your office to coordinate dates and supporting material.

Dr Ashley Bloomfield
**Director-General of Health**
Date:

Stephen McKernan
**Director, Transition Unit**
Date:

Hon Andrew Little
**Minister of Health**
Date:

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# Final Interim Government Policy Statement (iGPS) package for approval to issue and publish

## Background

1. On 16 June 2022 we provided you with a near-final draft of the interim Government Policy Statement (iGPS) on Health (including two of three technical appendices) for forwarding to the Ministerial Oversight Group on Health and Disability System Reform (Ministerial Oversight Group), for their feedback and approval in principle that it be issued subject to any minor and technical changes authorised by you [HR 20221051 refers].

2. The cover report to the Ministerial Oversight Group paper included two newly proposed measures which you asked us to do further work on and report back to you [HR 20220972 refers]. It also noted that the draft iGPS attached to the report had not yet been professionally proof-read or designed; and that we would advise you on the third iGPS technical appendix on data definitions.

3. These outstanding actions are now complete. The final iGPS is attached as Annex 1 for your approval, including the new 'data definitions' technical appendix. The changes we have made to the final iGPS are summarised below.

## Final updates to the iGPS

*Ministers' feedback*

4. Your office has passed on feedback from the Ministerial Oversight Group on the iGPS. The proposed changes include:

    a. a request from the Prime Minister to re-order the priority areas so that the chapter on equity is first, and other priorities follow from this;

    b. a request from the Minister of Finance that the section on financial objectives relating to capital should include an explicit statement about the expectation that depreciation funding is set aside for future asset renewal; and

    c. comments from other Ministers to elevate references to Pacific health in a small number of places in the iGPS objectives.

5. The above changes are generally minor and have been incorporated into the iGPS (these are highlighted in Annex 2 for your information).

6. Regarding the Prime Minister's feedback, we have moved the equity chapter to be the first of the priority areas in the document. The remaining chapters are in the same order as previously, except that we have also moved the chapter on "laying the foundations" to the end of the document (chapter six) as this covers cross-cutting settings.

7. We note that the intention was never to suggest a strict priority order in the chapters – each should be of equivalent weight. We have added text into the introduction, to be clear that all priorities have a relationship to Te Tiriti o Waitangi. We also note that the iGPS more widely reinforces a focus on Te Tiriti through the Ministerial foreword and in the other priority areas.

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*Entities' feedback*

8. We also sought final feedback from interim Health NZ (iHNZ) and the iMHA, including in the measures and the technical appendices. Interim Health NZ did not provide any further feedback.

9. The iMHA board and officials reiterated a previous recommendation to reduce the number of measures further, and to ensure alignment between the measures in the iGPS and the interim New Zealand Health Plan (iNZHP). As previously advised, we do not believe it is necessary to reduce measures further and the current set is proportionate to the task of monitoring Government priorities. We cannot at this stage advise on the precise alignment of measures with the iNZHP, as entities have not yet shared their detailed performance metrics. However, we do not anticipate an issue regarding consistency, as the iNZHP must give effect to the iGPS.

10. The iMHA also recommend adding a new measure to capture the proportion of health and disability services co-commissioned by MHA and HNZ. We have not made this change as we do not believe that this measure is readily collected, and we believe this type of measure would be more suitable for inclusion in the iNZHP.

11. Finally, the iMHA also noted the importance of definitions throughout the suite of measures and recommended amending measure 3.4 Ambulatory Sensitive Hospitalisations rates (ASH rates) to provide for reporting by ethnicity as well as key age groups. This was already the intention for analysis against this measure, and is noted in the data definition.

12. Officials from the iMHA had no further comment on the narrative of the iGPS.

## Further work on the two proposed iGPS measures

13. As you requested, we have engaged with the interim health entities and undertaken further analysis on two previously proposed additional measures:

    a. 4.6: attendance at emergency departments or after-hours for non-accidental presentations that could have been resolved in a primary care setting, reported by ethnicity and geographic area;

    b. 6.5: proportion of total spend on frontline health workforces, compared to governance, management, and administration support roles.

*Feedback from the interim Māori Health Authority*

14. The iMHA considered that the existing ASH rate (measure 3.4), together with patient-reported unmet need (measure 3.1), are sufficient indicators of unmet need in primary settings and that measure 4.6 is does not significant additional insight. However, they noted that measure 4.6 has some value in terms of measuring equity of access to health care for Māori, especially if trends were monitored over time and used with other baseline measures (and disaggregated by ethnicity and location).

15. The iMHA do not support the inclusion of proposed measure 6.5. They note that there is not currently a shared understanding of what the 'right' spend on corporate roles is, and that it is not clear how this measure will contribute to achieving health outcomes. They also consider that this measure will be difficult to quantify.

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*Feedback from the interim Health New Zealand*

16. Brief feedback from officials at iHNZ noted that the proposed measures are possible, but that work is needed to set the right performance expectations over the first two years. Regarding measure 6.5, officials noted that the new health entities will need flexibility to place resources where they are most needed to manage the change processes, leading to possible fluctuations. In terms of reporting, officials noted that both measures have the potential to be unhelpful if they were to be compared quarter on quarter.

*Recommended way forward*

17. While both measures have potential merit, following our engagement and analysis we do not recommend that the existing iGPS measures be amended to include the proposed two new measures at this stage. Instead, we suggest that the intent of the proposed measures be picked up in other ways (where possible):

    a. For proposed measure 4.6, we intend to explore expanding the existing ASH rate measure (3.4) to report disaggregation by time (e.g. after hours) and location (e.g. emergency department presentations). This should support greater focus on these areas as the iGPS measures are developed.

    b. For proposed measure 6.5, we proposed considering how workforce utilisation and administrative costs can be incorporated within the work to develop measures of productivity (existing measure 6.2). We anticipate that this could include measures such as hospital theatre utilisation, Full Time Equivalents (FTEs) per case-weighted hospital discharge, use of (clinical and non-clinical) workforce.

18. Data definitions have been updated to note the two areas of further development as above. Should you agree to the proposal to not include these measures specifically at this stage, no further action is required.

## The 'data definitions' technical appendix

19. The third iGPS technical appendix on 'data definitions' for the iGPS measures is included in the attached iGPS (pages 49-68). The definitions are technical, so were not included in the iGPS package the went to the Ministerial Oversight Group for approval in principle to issue the iGPS.

20. We have developed these definitions to ensure there is clarity on the key elements that will support reporting and tracking the progress for the Government's priorities. This includes, for example, the desired change in performance trends, common measure definitions, data sources, and frequency of reporting.

21. The data definitions:

    - identify baselines and performance expectations associated with each measure for the period July 2022 to June 2024.
    - confirm technical details around the measures themselves such as the data source; numerators and denominators or qualitative requirements, and link to existing measure sets such as Whakamaua, if applicable.
    - confirm data periods covered by the measure (e.g. rolling six or 12-monthly, quarterly).
    - confirm the frequency of reporting for example monthly or quarterly.

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- confirm how reporting will be disaggregated for example by age, ethnicity or gender etc.

22. Overall, the majority of iGPS measures are existing and have established baseline points to assess progress against. At the 30 May 2022 Joint Minister's meeting we discussed key reporting with you and the importance of ensuring there is a view of information by population demographics to support a view of equity. The default position is that all measures will be reported disaggregated by ethnicity, age, gender, and geographic area where appropriate, and as data allows.

*Engagement with entities*

23. The Ministry and Transition Unit have worked closely with interim Health New Zealand (iHNZ) and the interim Māori Health Authority (iMHA) to develop and confirm the technical details for the iGPS measures.

24. In response to feedback from health entities a handful of new measures were introduced to focus progress reporting on reform shifts. New measures were introduced to report against these areas.

*Definitions will be developed further with entities over the next six to 12 months*

25. Some definitions are still in development. This is where data sources and definitions need to be developed collectively with sector stakeholders over the next six to 12 months before baselines and expectations can be identified. Over the first six months of 2022/23, the Ministry, HNZ, and MHA will continue to develop the data definitions for the suite of measures, including six which are new and will require joint agreement and/or the establishment of a baseline during the first year of the reforms. We will update you on the refreshed data definitions and accompanying options for performance expectations by 15 January 2023.

26. As such, this iGPS technical appendix will need to be continuously maintained as the definitions are confirmed or adjusted, with updates made available on the Ministry website. We will seek your agreement to any significant changes to the measures that are still in development.

*Baselines and expectations for 2022 – 2024*

27. We seek your agreement to the details set out in Annex 6 on the:
    a. proposed starting point (baseline) for measuring change in progress for each measure; and
    b. direction of change expected through to 2024.

28. Baselines are proposed for all the iGPS measures. Where baselines are currently in place these are noted and included in the data definitions. Where baselines will need to be established, based on results during the interim period to 2024, we will need to update the definitions for some of these measures to reflect these changes and will seek your feedback through future monitoring processes.

29. Expectations for change from baseline are also set out in Annex 6. These expectations apply to the interim period to June 2024. We acknowledge that longer term expectations may reflect different goals or direction of change. For example, in the short term the system may seek growth in admission rates to hospital to address a current delivery gap

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while longer-term goals may be to avoid admission or provide services in the community. For some measures, expectations will be confirmed during the interim period to 2024, and measure definitions will be updated to reflect these. We seek your agreement to these expectations.

## Issuing the iGPS to health entities

30. We propose that you send letters to the five health entities under the Pae Ora Act who will be expected to give effect to the iGPS. These letters would communicate your approval of the iGPS and its imminent publication, and clarify your expectation that these entities will all give effect to the iGPS. We propose sending them on Thursday 30 June, the day before the iGPS is published and comes into effect.

31. In relation to the Pharmaceutical Management Agency, Health Quality and Safety Commission and the New Zealand Blood and Organ Service (as existing Crown agents), we propose you sign the attached letters to these entities directing them to give effect to the iGPS in undertaking their functions and objectives, under section 103 of the Crown Entities Act 2004. These letters would then follow on from previous letters of expectation.

32. In relation to Health NZ and the MHA, we proposed you sign the attached letters to the interim Board chairs, outlining the requirement from 1 July 2022 for the new entities to give effect to the iGPS.

33. We also propose that you send letters to other entities in the wider health sector: the Health and Disability Commissioner, the Mental Health and Wellbeing Commissioner, and the Health Research Council. Although these entities are not required to give effect to the iGPS, its content and direction will be very relevant to their functions, and we expect the entities will wish to consider their fit with Government priorities. Draft letters are attached for your review to share with these entities.

34. The signed letters will have the final iGPS attached. We will work with your office to send the final version to be published with the letters to each entity.

## Next steps

35. While not a legal requirement, we recommend you issue the iGPS on 1 July 2022 to mark the first day of the reformed system and coincide with the Pae Ora Act 2022 coming into force. Subject to your approval, we expect that this will entail the following steps:

    a. The attached version of the iGPS approved by you on Thursday 30 June, for any final minor changes.

    b. The iGPS is sent to health entities (with attached covering Ministerial letters) on Thursday 30 June.

    c. The iGPS is published on the Ministry's website on 1 July, and tabled in the House of Representatives as soon as practical thereafter.

36. We are working with your office on any communications material needed to support the publication of the iGPS. We will also work with your office to confirm dates and supporting material for you to table the final iGPS in the House of Representatives, as soon as practical.

37. Following the publication of the iGPS, the Ministry will start its work implementing and monitoring the iGPS, including working with the new health entities on the measures. We will report back to Ministers.

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Dr Dale Bramley
Chair
Health Quality and Safety Commission
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Tēnā koe Dale

**Interim Government Policy Statement on Health**

I am writing to advise you of the interim Government Policy Statement on Health, attached as Annex 1 to this letter.

The interim Government Policy Statement on Health sets the Government's expectations and priorities over the first two years of the reformed health system, 2022–2024. The six priorities identified align with the system shifts and priority outcomes expected from the reformed health system. Making these changes for the health system will take time, investment and all health entities and the health sector pulling together.

The interim Government Policy Statement on Health will be in effect until the first Government Policy Statement is issued under the Pae Ora (Healthy Futures) Act 2022, before 1 July 2024.

As previously advised in my Letter of Expectations to you of 31 March 2022, I expect the Health Quality and Safety Commission to give effect to the interim Government Policy Statement on Health in undertaking its functions. This will continue work towards the health system vision of 'Pae ora – healthy futures'.

Ngā mihi nui

Hon Andrew Little
**Minister of Health**

cc Dr Janice Wilson, Chief Executive, HQSC, janice.wilson@hqsc.govt.nz

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Document 9C

Hon Steve Maharey
Chair
Pharmac
steve.maharey@pharmac.govt.nz

Tēnā koe Steve

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The interim Government Policy Statement on Health will be in effect until the first Government Policy Statement is issued under the Pae Ora (Healthy Futures) Act 2022, before 1 July 2024.

As previously advised in my Letter of Expectations to you of 31 March 2022, I expect Pharmac to give effect to the Interim Government Policy Statement on Health in undertaking its functions. This will continue work towards the health system vision of 'Pae ora – healthy futures'.

Ngā mihi nui

Hon Andrew Little
**Minister of Health**

cc Sarah Fitt, Chief Executive, Pharmac, sarah.fitt@pharmac.govt.nz

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Document 9C

Fiona Pimm
Chair
New Zealand Blood and Organ Service
boardchair@nzblood.co.nz

Tēnā koe Fiona

**Interim Government Policy Statement on Health**

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The interim Government Policy Statement on Health will be in effect until the first Government Policy Statement is issued under the Pae Ora (Healthy Futures) Act 2022, before 1 July 2024.

As previously advised in Hon Peeni Henare's Letter of Expectations to you for 2022/23, I expect the New Zealand Blood and Organ Service to give effect to the Interim Government Policy Statement on Health in undertaking its functions, where relevant. This will continue work towards the health system vision of 'Pae ora – healthy futures'.

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Ngā mihi nui

Hon Andrew Little
**Minister of Health**

cc Hon Peeni Henare, Associate Minister of Health

cc Sam Cliffe, Chief Executive, New Zealand Blood and Organ Service, sam.cliffe@nzblood.govt.nz

Rob Campbell
Chair
Interim Health New Zealand

Tēnā koe Rob

**Interim Government Policy Statement on Health**

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From 1 July 2022, when Health New Zealand is established as a crown agent, I expect Health New Zealand to give effect to the interim Government Policy Statement on Health in undertaking its functions and objectives, under section 103 of the Crown Entities Act 2004.

The interim Government Policy Statement on Health sets parameters for the interim New Zealand Health Plan, as the plan for the delivery of publicly funded health services should give effect to the interim Government Policy Statement. I look forward to being provided for approval the interim New Zealand Health Plan, prepared in partnership by the Māori Health Authority and Health New Zealand, after the establishment of the entities and the completion of work developing the plan.

The interim Government Policy Statement on Health will be in effect until the first Government Policy Statement is issued under the Pae Ora (Healthy Futures) Act 2022, before 1 July 2024.

I thank Health New Zealand for their contribution to the development of the interim Government Policy Statement on Health.

Ngā mihi nui

Hon Andrew Little
**Minister of Health**

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Document 9D

Sharon Shea and Tipa Mahuta
Co-Chairs
Interim Māori Health Authority

Tēnā kōrua Sharon and Tipa

**Interim Government Policy Statement on Health**

I am writing to advise you of the interim Government Policy Statement on Health, attached as Annex 1 to this letter.

The interim Government Policy Statement on Health sets the Government's expectations and priorities for the health system over the first two years of the reformed health system, 2022–2024. The six priorities identified align with the system shifts and priority outcomes expected from the reformed health system. Making these changes for the health system will take time, investment and all health entities and the health sector pulling together.

From 1 July 2022, when the Māori Health Authority is established as a crown agent, I expect the Māori Health Authority to give effect to the interim Government Policy Statement on Health in undertaking its functions and objectives, under section 103 of the Crown Entities Act 2004.

The interim Government Policy Statement on Health sets parameters for the interim New Zealand Health Plan, as the plan for the delivery of publicly funded health services should give effect to the interim Government Policy Statement. I look forward to being provided for approval the interim New Zealand Health Plan, prepared in partnership by the Māori Health Authority and Health New Zealand, after the establishment of the entities and the completion of work developing the plan.

The interim Government Policy Statement on Health will be in effect until the first Government Policy Statement is issued under the Pae Ora (Healthy Futures) Act 2022, before 1 July 2024.

I thank the interim Māori Health Authority for their contribution to the development of the interim Government Policy Statement on Health.

Ngā mihi nui

Hon Andrew Little
**Minister of Health**

cc Hon Peeni Henare, Associate Minister of Health

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Document 9E

Hayden Wano
Chair
Mental Health and Wellbeing Commission
hayden.wano@mhwc.govt.nz

Tēnā koe Hayden

**Interim Government Policy Statement on Health**

I am writing to advise you of the publication of the interim Government Policy Statement on Health, attached as Annex 1 to this letter.

The interim Government Policy Statement on Health sets the Government's expectations and priorities over the first two years of the reformed health system, 2022–2024. This will continue work towards the health system vision of 'Pae ora – healthy futures'. The six priorities identified align with the system shifts and priority outcomes expected from the reformed health system. Making these changes for the health system will take time, investment and all health entities and the health sector pulling together.

The interim Government Policy Statement on Health will be in effect until the first Government Policy Statement is issued under the Pae Ora (Healthy Futures) Act 2022, before 1 July 2024.

Ngā mihi nui

Hon Andrew Little
**Minister of Health**

cc Karen Orsborn, Chief Executive, MHWC, karen.orsborn@mhwc.govt.nz

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Morag McDowell
Health and Disability Commissioner
morag.mcdowell@hdc.org.nz

Tēnā koe Morag

**Interim Government Policy Statement on Health**

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The interim Government Policy Statement on Health sets the Government's expectations and priorities over the first two years of the reformed health system, 2022–2024. This will continue work towards the health system vision of 'Pae ora – healthy futures'. The six priorities identified align with the system shifts and priority outcomes expected from the reformed health system. Making these changes for the health system will take time, investment and all health entities and the health sector pulling together.

The interim Government Policy Statement on Health will be in effect until the first Government Policy Statement is issued under the Pae Ora (Healthy Futures) Act 2022, before 1 July 2024.

Ngā mihi nui

Hon Andrew Little
**Minister of Health**

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Tēnā koe Lester

**Interim Government Policy Statement on Health**

I am writing to advise you of the publication of the interim Government Policy Statement on Health, attached as Annex 1 to this letter.

The interim Government Policy Statement on Health sets the Government's expectations and priorities over the first two years of the reformed health system, 2022–2024. This will continue work towards the health system vision of 'Pae ora – healthy futures'. The six priorities identified align with the system shifts and priority outcomes expected from the reformed health system. Making these changes for the health system will take time, investment and all health entities and the health sector pulling together.

The interim Government Policy Statement on Health will be in effect until the first Government Policy Statement is issued under the Pae Ora (Healthy Futures) Act 2022, before 1 July 2024.

Ngā mihi nui

Hon Andrew Little
**Minister of Health**

cc Hon Dr Ayesha Verrall, Minister of Research, Science and Innovation

cc Sunny Collings, Chief Executive, Health Research Council of New Zealand, scollings@hrc.govt.nz

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**Annex 6**

**iGPS measure baseline and expectation for 2022 to 2024**

| iGPS priority | iGPS measure | | Baseline | Expectation for July 2022 – June 2024 |
|---|---|---|---|---|
| 1<br><br>Achieving equity in health outcomes | 1.1 | Variation of clinical prioritisation for cancer treatment and elective surgery, reported by ethnicity and geographic area Result for the 12 months to 30 June 2022 | Note: Initially this measure will reflect Elective Services Patient Flow Indicator 8. | 100% of patients were prioritised using approved nationally recognised processes or tools |
| | 1.2 | Proportion of people who start first treatment for breast, cervical and bowel cancer after a screen result (presence of cancer), where required, reported by ethnicity and geographic area Measure definitions to be developed for breast, cervical and bowel cancer based on existing metrics | Baseline and expectations to be confirmed | TBC |
| | 1.3 | 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 | A) Surgery, first specialist assessments and colonoscopies – Establish a baseline in year one<br><br>B) Gender affirming care and screening - Measure definition to be developed<br><br>C) Access to specialist mental health for rangatahi – Results for the 12 months to 30 June 2022 | A) The baseline will inform an expectation for year two<br><br>B) TBC<br><br>C) An increase in the percentage of people seen within the target timeframe |
| | 1.4 | Missed appointments for specialist care, reported by ethnicity and geographic areaResults for the 12 months to 30 June 2022 | A) Missed appointments<br><br>B) Equity gap between Māori, Pacific people and non-Māori/non-Pacific peoples. | A) Decrease from baseline<br><br>B) Decrease from baseline |

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| iGPS priority | iGPS measure | | Baseline | Expectation for July 2022 – June 2024 |
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| | 1.5 | Rate of diabetes complications, reported by ethnicity and geographic area | Results for the 12 months to 30 June 2021 | Decrease from baseline |
| **iGPS priority** | **iGPS measure** | | **Baseline** | **Expectation for July 2022 – June 2024** |
| 2<br><br>Embedding Te Tiriti o Waitangi across the health system | 2.1 | Health entity spending on Māori health service providers | Average of last five financial years | Increase in trend in actual expenditure |
| | 2.2 | Experience of health services for Māori as measured by the primary health care and adult inpatient patient experience surveys | Results from June 2021 (baseline used in Health System Indicators) | Improvement in experience |
| | 2.3 | Geographical coverage and utilisation of rongoā Māori service | As identified in Whakamaua dashboard | Increase in volumes and spread across the country |
| | 2.4 | Feedback from the Iwi Māori Partnership Boards on how they are fulfilling their role and whether they are receiving the support they require | Establish a baseline in year one | Agreed change or improvement in year two (from year one baseline) |
| **iGPS priority** | **iGPS measure** | | **Baseline** | **Expectation for July 2022 – June 2024** |
| 3<br><br>Keeping people well in their communities | 3.1 | Proportion of people reporting unmet need for primary health care, reported by ethnicity and geographic area | Result for the 12 months to 30 June 2019<br><br>Note: As part of the New Zealand Health Survey programme, this measure is due to be replaced in 2023 and the iGPS measure definition will be revised | A decrease from the baseline |
| | 3.2 | Proportion of people waiting for planned specialist care who receive it within four months, reported by ethnicity and geographic area | Result for the 12 months to 30 June 2022<br><br>A) First Specialist Assessment (FSA) (as per current Elective Services Patient Flow Indicator (ESPI) 2 measure)<br>B) Elective treatment for patients who were given a commitment to treatment (as per current ESPI 5 measure) | Improvement towards meeting the following goals:<br>A) No patients waiting for a First Specialist Assessment (FSA) wait longer than four months (as per current ESPI 2 measure)<br><br>B) No patients are given a commitment to treatment and are not treated in within four months (as per current ESPI 5 measure) |

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| | 3.3 | Uptake of immunisations for key age groups, reported by ethnicity and geographic area | Results as at December 2019 (baseline used in Health System Indicators) | Improvement towards meeting the following goals:<br>• 95% of eligible children full immunised at eight months of age for Māori, Pacific and Total population<br>• 95% of eligible children fully immunised at two years of age for Māori, Pacific and Total population<br>• 95% of eligible children fully immunised at five years of age for Māori, Pacific and Total population<br>• 75% of eligible boys and girls fully immunised with HPV vaccine for Māori, Pacific and Total population<br>• 75% of eligible population aged 65 years and over immunised against influenza (annual immunisation) for Māori, Pacific and Total population |
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| 3<br><br>Keeping people well in their communities | 3.4 | Rate of hospital admissions for an illness that might have been prevented or better managed in the community, reported by key age groups | Results as at December 2019 (baseline used in Health System Indicators)<br>A) For children under five for an illness that might have been prevented or better managed in the community; and equity gap between Māori, Pacific people and non-Māori non-Pacific peoples<br>B) For people aged 45–64 for an illness that might have been prevented or better managed in the community; and equity gap between Māori, Pacific people and Non-Māori /non-Pacific peoples | Reduction from baseline and/or equity gap between Māori, Pacific people and non-Māori non-Pacific peoples reduces |
| | 3.5 | Complete roll-out of the Access and Choice programme for primary mental health and addiction support services so that access is available for | Establish baseline estimated annual access level in first quarter of 2022/23<br><br>A) Integrated Primary Mental Health and Addiction Services: annual access | Progress towards: |

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| | | 325,000 people per year by end of June 2024 | level based on first quarter of 2022/23<br>B) Kaupapa Māori, Pacific and Youth Primary Mental Health and Addiction Services: annual access level based on first quarter of 2022/23 | A) Estimated 248,000 annual access level based on fourth quarter access in 2023/24<br>B) Estimated 77,000 annual access level based on fourth quarter access in 2023/24 |
| | 3.6 | Enrolment with a primary maternity care provider in the first trimester of pregnancy, reported by ethnicity and geographic area | Establish a baseline in year one | Agreed change or improvement in year two (from year one baseline) |
| | 3.7 | Standardised rate of acute readmissions within 28 days of discharge, reported by ethnicity and geographic area | Establish a baseline in year one | Improvement in year two (from year one baseline) |
| **iGPS priority** | **iGPS measure** | | **Baseline** | **Expectation for July 2022 – June 2024** |
| 4<br>Developing the health workforce of the future | 4.1 | Engagement survey of staff on culture and shift towards one team ethos (measure will be in development as work to build data collection) | Measure definition to be developed | TBC |
| | 4.2 | Proportion of Māori and other under-represented groups in the regulated and unregulated health workforce, compared to the demographics of the total population | A) Regulated workforce – Results for the 12 months to 30 June 2022<br>B) Unregulated health workforce - Results for the 12 months to 30 June 2022 (initially this will focus on unregulated HNZ employed workforce) | A) An increase from the baseline<br>B) An increase from the baseline |
| | 4.3 | Number and proportion of graduates of health training programmes from demographic groups under-represented in health workforce, compared to the demographics of the total population | Measure definition to be developed | TBC |

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| iGPS priority | iGPS measure | | Baseline | Expectation for July 2022 – June 2024 |
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| | 4.4 | Proportion of Māori and Pacific people in leadership and governance roles across the Ministry of Health and health entities | Establish a baseline in year one | An initial increase in numbers in year two |
| **iGPS priority** | **iGPS measure** | | **Baseline** | **Expectation for July 2022 – June 2024** |
| 5<br><br>Ensuring a financially sustainable health system | 5.1 | Actual expenditure is consistent with budgeted and there is overall balance in both budgeted and actual revenue to expenditure ratios | N/A | A) Actual expenditure does not exceed the approved budget or funding received<br>B) When budgeting, expenditure is expected to be realistically proportioned to the funding signals<br>C) Expenditure is managed against the multi-year financial plan (including cost pressures are managed to ensure financial sustainability goals are achieved) |
| | 5.2 | Develop and monitor agreed measures of quality-adjusted, system-level productivity | Measure definitions to be developed | TBC |
| | 5.3 | At a system level, monitor the proportion of total expenditure directed to mental health and addiction, public health, and primary and community care services and initiatives | Measure definition to be developed | TBC |
| | 5.4 | Develop an Investment Strategy and National Asset Management Strategy by December 2023 | N/A | Develop an Investment Strategy and National Asset Management Strategy by December 2023 |
| **iGPS priority** | **iGPS measure** | | **Baseline** | **Expectation for July 2022 – June 2024** |
| 6<br><br>Laying the foundations for | 6.1 | Health entities are clear about their own and other entities' roles and responsibilities, and are delivering to these | Measures to be developed | TBC |

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| the ongoing success of the health system | 6.2 | Experience of primary health care and adult inpatient health services measured across demographic groups using patient experience surveys | Results from June 2021 (baseline used in Health System Indicators) | Improvement in experience |
| | 6.3 | Proportion of entities who have been assessed against the Consumer Engagement Quality and Safety Marker; and of those, the proportion who have been assessed at Level 3 or 4 | Establish baseline for Consumer Engagement Quality and Safety markers for entities or local or regional offices of the entities, as agreed, who have been assessed at level 3 or 4. | Agreed change or improvement in year two (from year one baseline) |
| | 6.4 | Proportion of medical appointments completed through digital channels (initially outpatients and expanding to include GP appointments when data is available). | Establish a baseline for the First Specialist Assessment (FSA) and follow ups in year one. | Agreed change or improvement in year two (from year one baseline) |

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