Regulatory Impact Statement: Decision on the organisational form of a Māori Health Authority

Coversheet

Purpose of Document	
Decision sought:	Policy decisions on the organisational form, governance and accountability arrangements for the Māori Health Authority
Advising agencies:	Department of Prime Minister and Cabinet (Health Transition Unit)
Proposing Ministers:	Minister of Health
Date finalised:	2 September 2021

Context and Problem Definition

In March 2021 Cabinet agreed to substantial reform of the New Zealand Health and Disability system, accepting the case for change articulated by the Health and Disability System Review[1] and in the Waitangi Tribunal's Health Services and Outcomes Inquiry (Wai 2575)[2]. Within a wider problem definition, these reviews made specific findings that the system does not operate in partnership with Māori, meet the Crown's Treaty of Waitangi obligations, or deliver equity in health outcomes to Māori.

Cabinet agreed to establish a new statutory entity, provisionally called the Māori Health Authority (MHA), to lead hauora Māori in the health system. It agreed this entity should be independent of other health system organisations and constituted in a way that gives effect to rangatiratanga and embeds the principle of partnership between Māori and the Crown.

Cabinet has agreed that this entity will:

- jointly develop national health strategies and policies which impact on hauora Māori with the Ministry of Health;
- jointly develop and agree service plans with Health New Zealand (HNZ - the lead operational entity in the new system);
- commission kaupapa Māori health services and other services targeted for Māori;
- co-commission other health services accessed by Māori, working jointly with Health New Zealand to approve commissioning plans/priorities;

[1] https://systemreview.health.govt.nz/

[2] https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf

- monitor the performance of HNZ in delivering priorities for Māori, including against the Māori Health Plan, and the wider health system's performance for Māori (in partnership with the Ministry of Health);
- lead and foster the development of the Māori workforce and Māori service providers, including kaupapa Māori models of care; and
- support Iwi Māori Partnership Boards to strengthen the understanding and response of the health system to the health needs, aspirations and priorities of local Māori communities.

An organisational form is needed for the MHA that will ensure it can:

- engage and partner with Māori effectively (in accordance with tikanga) in order to understand the Māori perspective;
- reflect that perspective meaningfully and efficiently in strategy and policy work, and in the planning, design, and commissioning of services at a national and regional level and in its monitoring and workforce support functions;
- partner specifically with Iwi-Māori Partnership Boards to make the link between the needs and aspirations expressed at a locality level and planning & commissioning at national and regional levels; and
- be clearly accountable to Māori, Ministers and the wider New Zealand public (including under the Public Finance Act 1989) for the exercise of its functions.

Executive Summary

We have considered whether the MHA should take the form of a Crown Agent under the Crown Entities Act 2004, or a fully independent statutory entity. After analysis, we propose a deliberate hybrid of these options, where the MHA would take an organisational form that utilises the key governance and accountability mechanisms of statutory entities under the Crown Entities Act, but with modifications to explicitly provide for a Māori perspective and more direct accountability to Māori (see **Option Two, Appendix Two** for a full description).

This option ensures an essential level of public financial accountability, places the MHA in the strongest possible position to impact on health inequities, and provides the most balanced approach to wider accountability and a constructive relationship between the Crown and the MHA. This option is supported by the Steering Group chaired by Tā Mason Durie, and we consider it the best possible option for inclusion in the Health Reform Bill.

Costs and benefits have been assessed using a form of 'reverse analysis' where the organisational costs of the MHA are compared with select examples of monetised benefits (health outcomes or fiscal cost savings) that would arise from reducing inequities between Māori and non-Māori in the coverage or effectiveness of particular health services.

Costs exclude any potential additional or ring-fenced commissioning budget for the MHA as funding decisions on such matters are yet to be considered. Benefits are scaled to conservative proportions (20-30%) to reflect our hypothesis of how much impact the MHA would have on the selected disparities even if no additional or ring-fenced commissioning budget was provided for kaupapa Māori services.

This analysis yields estimated benefits of between $297 and $362million (present value), compared with organisational costs of $282 million (present value) for the MHA. Given

that the benefit examples represent only a portion of likely benefits to health outcomes or fiscal cost savings, and the wide nature of unquantifiable benefits (to outcomes such as productivity, social trust, or the health of the Māori-Crown relationship), this analysis gives high confidence that the benefits of the MHA will significantly outweigh the costs.

Limitations and constraints on analysis

The scope of options considered for the organisational form of the MHA was limited by Cabinet's previous decision to establish it as a statutory entity, which has ruled out the options of a Business Unit or a Departmental Agency within a Public Service Department.

This decision was based on the perspective that a departmental form (with the very close ministerial relationship that implies) would not adequately reflect the Treaty relationship, would not empower the MHA to adequately express the Māori perspective, and would not provide sufficient accountability to Māori.

The 'reverse analysis' approach to the CBA has been used because:

- we often do not have data about the QALY gains from greater uptake or effectiveness of particular services for Māori (this evaluation and evidence base has not been adequately resourced to date);
- we do not always have ethnic-specific usage data from which we can isolate the fiscal cost of interventions for Māori;
- some fiscal cost savings from more effective initial interventions will be offset by revealing need that is currently unmet, and this is not well understood; and
- we cannot predict (with any precision) the total extent to which the operation of the MHA will contribute to improved outcomes for Māori: it will work at every level of the health system and may influence any aspect of health services or programmes. We have therefore selected examples for detailed analysis, rather than attempt to quantify the overall benefit.

Responsible Manager(s) (completed by relevant manager)

Stephen McKernan

Director, Health Transition Unit

Department of Prime Minister and Cabinet

2 September 2021

Quality Assurance (completed by QA panel)

Reviewing Agency:	DPMC and Ministry of Health
Panel Assessment & Comment:	The Panel considers that the RIA Meets the Quality Assurance Criteria. The Panel noted that it was hard to develop a full regulatory impact assessment for a machinery of government issue, in this case the choosing between different organisational forms. This is

	because it is not possible or practical to distinguish between the overall costs and benefits of creating a Māori Health Agency (which has already been decided), and those associated with the question of organisational form. This is a similar situation faced in producing other RIAs of a comparable nature e.g. for Taumata Arawai, the Criminal Case Review Commission, the role of the Reserve Bank Governor on its Board, and the Independent Mental Health and Wellbeing Commission. In this case the decision to form the Māori Health Authority has already been made, and the remaining decision (the focus of the RIA) is organisational form. This RIA clearly outlines the benefits that could be gained in Māori health status through the effective functioning of the Māori Health Authority. The approach taken is robust, and based on available evidence. The Multi-Criteria Analysis teases out the trade-offs and nuances between the different choices of organisational form, and allows a clear choice to be made. There has been considerable general consultation and engagement on these issues, and the advice of an expert panel, on these matters. The Select Committee process will provide the opportunity for further detailed stakeholder input.

Section 1: Context & Problem Definition

Previous reviews of the Health and Disability System

1. The Health and Disability System Review (the review), the Waitangi Tribunal's Health Services and Outcomes Inquiry (Wai 2575) and several reviews over past decades have undertaken comprehensive public consultation and sector engagement on the New Zealand Public Health and Disability System, finding that it:

   - is highly fragmented and lacks cohesion, with different actors and organisations often pulling in different directions, unwarranted variation in performance and a failure to innovate or scale new practice;
   - too often designs services around the interests of certain providers, rather than what consumers value and need;
   - fails to operate in partnership with Māori or meet the Crown's Treaty obligations;
   - fails to deliver equity in health outcomes (particularly for Māori, Pacific peoples, and disabled people); and
   - faces significant financial pressures, mounting deficits, and challenges to long-term affordability.

2. Allowing the status quo to continue is likely to further widen health inequities, further exacerbate fiscal cost, have an ongoing negative impact on the Māori-Crown relationship, and place unsustainable pressure on the health sector workforce.

Specific Cabinet decisions already made

3. Cabinet has agreed to a suite of system-wide reforms based on a vision of '**Pae ora/healthy futures for all**', with these reforms to be driven by the following priority outcomes:

   - **equity**: tackling the gap in access and health outcomes between different populations and areas of New Zealand;
   - **partnership**: ensuring partnership with Māori in decisions at all levels of the system, and empowering consumers to design services which work for them;
   - **sustainability**: embedding population health as the driver of preventing and reducing health need, and promoting efficient and effective care;
   - **person and whānau-centred care**: empowering all people to manage their own health and wellbeing and have meaningful control over the services they receive, and treating people, their carers and whānau as experts in care; and
   - **excellence**: ensuring consistent, high-quality care in all areas, and harnessing innovation, digital and new technologies to continuously improve services [CAB-21-MIN-0092 refers[3]].

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[3] https://dpmc.govt.nz/publications/cabinet-decision-cab-21-sub-0092-health-and-disability-system-review-proposals-reform

4. Cabinet has also made a number of specific decisions about reform [CAB-21-MIN-0092 & SWC-21-MIN-0107 refer], and the most significant of these are summarised under the following headings.

Revised statutory purpose, goals, and principles

5. Cabinet has decided to repeal and replace the New Zealand Public Health and Disability Act 2000, agreeing to set out:

    - An **overall purpose in the Health Reform Bill**: *to provide for the public funding and provision of health services, and establish publicly-owned health organisations in order to protect, promote and improve health and achieve pae ora/healthy futures for all New Zealanders;*
    - a **general duty on publicly-funded health organisations** to undertake best efforts to achieve the priority goals agreed by Cabinet within each organisation's functions and the funding made available;
    - **specific principles** which organisations must have regard to in meeting their obligations to promote equity, including:
        - to ensure equitable health outcomes for all groups, regardless of gender, ethnicity, sexuality, condition, disability, place of residence, etc;
        - to improve, prevent, diagnose and treat both physical and mental health problems with equal regard;
        - to provide all people with an equitable range and quality of services, according with their views, wishes and beliefs; and
        - to make decisions and provide services having regard to all of a person's circumstances and not based solely on a person's age or disability.

6. Cabinet has also agreed that **replacement legislation will place obligations on health sector entities in respect of the Treaty of Waitangi** by including a Treaty of Waitangi clause following the standard modern form, that gives effect to the principles identified by the Waitangi Tribunal in its Hauora inquiry[4].

7. Other provisions of the legislation will give effect to the reform components discussed under the subsequent headings.

Institutional settings/system operating model

8. Cabinet has agreed to the following institutional features of a system operating model:

    - a strengthened Ministry of Health as the chief steward of the health system and principal advisor to the Minister of Health on strategy and policy, with a specific stewardship role in respect of Pacific health and disability;
    - a new Crown entity (Crown Agent), provisionally called Health New Zealand (HNZ), that will lead operational organisation and the planning, commissioning

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[4] https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf p 163-2

and delivery of services in the public health system within the parameters set by the Minister in national strategies and policies;

- the disestablishment of all district health boards, with their assets and liabilities vested in Health New Zealand, and relevant operational functions of the Ministry of Health transferred to Health New Zealand;
- a new statutory entity, provisionally called the Māori Health Authority (MHA), to lead hauora Māori in the health system, work with the Ministry of Health on strategy and policy relating to hauora Māori, and work with Health New Zealand on operational matters (***see decisions on hauora Māori below for more specificity about the functions of the MHA***);
- a Public Health Agency established as a branded unit within the Ministry of Health to lead on public and population health policy, strategy, regulatory, intelligence, surveillance and monitoring functions, and a national public health service within Health New Zealand encompassing the 12 existing public health units;
- a New Zealand Health Charter that will set out common values and principles to guide organisations and health and care workers across the system.

9. It is also expected that:

    - Health NZ will organise itself into regional divisions for the planning and provision of hospital and specialist services and the planning and commissioning of primary and community health services; and
    - although HNZ will set some funding and service requirements at a national level, commissioners would look to design and provide primary and community services through networks of providers in 'localities' at a sub-district level. These locality networks will place a greater emphasis on population health and help shift from the often-fragmented approach of contracting individual providers to one where providers for a given locality share common outcomes, systems, practice, and management functions.

Strategy, planning and accountability framework

10. Cabinet has agreed to the following components of a future planning, accountability and intervention framework for the health system:

    - a New Zealand Heath Strategy to set the overall direction and long-term objectives for the sector;
    - national strategies for hauora Māori, Pacific health, and health of disabled people;
    - a Government Policy Statement issued by the Minister of Health to set a multi-year national direction, including priorities and objectives for the health system, in line with the New Zealand Health Strategy;
    - a New Zealand Health Plan (aligned to the budget cycle and giving effect to the GPS), which would set out a long-term health service view, define national service requirements and specifications, and form the basis for wider planning of system enablers such as capital, digital and workforce needs; and

- locality plans that set out priority health outcomes, equity targets and services for the locality (subject to the requirements of the NZHP) and involve social sector agencies and other entities that contribute to population health.

Hauora Māori

11. Cabinet has also made a number of specific decisions (subject to detailed design) aimed at addressing the Crown's Treaty of Waitangi obligations and inequity in health outcomes for Māori. In addition to the Treaty provisions provided for in the statutory purpose and principles section above, and the decision to establish a Māori Health Authority, Cabinet has agreed that:

    - the Māori Health Authority should be independent of other health system organisations, and constituted in a way that gives effect to rangatiratanga and embeds the principle of partnership between Māori and the Crown;
    - the MHA will:
        - jointly develop national strategies and policies that relate to hauora Māori with the Ministry of Health;
        - jointly develop national and regional service plans with Health New Zealand and will need to co-sign or approve these plans or strategies before they come into effect (including the NZHP and Locality Plans);
        - be a lead commissioner of kaupapa Māori health services and other services targeted for Māori; and
        - act as a co-commissioner for other health services accessed by Māori, working jointly with HNZ to approve commissioning plans/priorities.

12. The current paper entitled *Health and Disability System Review – further policy decisions for the Health Reform Bill* also seeks confirmation that the MHA will perform a monitoring role in relation to:

    - the performance of HNZ against its agreed objectives for hauora Māori (as set out in a Māori Health Plan to be developed); and
    - the wider health system's performance for Māori (in partnership with the Ministry).

13. In line with the review and statements in the White Paper, the reforms are also likely to consider options for developing the Māori workforce and Māori service providers. Initiatives that respond to these needs are likely to be progressed through or in conjunction with the MHA.

14. Notwithstanding the importance of the MHA, Cabinet has also been clear that it cannot on its own represent the voice of Māori. Rangatiratanga resides with hapū and iwi, and Iwi-Māori partnership boards (IMPBs) have played a critical role in articulating the needs and aspirations of Māori at a local level. However, although there are 20 existing IMPBs, each has been formed independently with their local District Health Board (DHB), meaning their role, scope, composition and influence on decision-making varies considerably. In most cases, their role is largely advisory and agendas often reflect DHB matters rather than local Māori community needs, aspirations and priorities. They are generally not resourced to engage with their local communities to identify needs, and to develop strategic priorities to advance with their local DHB.

15. As such, Cabinet has agreed that the role of iwi/Māori partnership boards should be significantly strengthened in the future, to act as the principal Treaty partner to HNZ at the locality level. To achieve this, the Health Reform Bill will need to identify the boards clearly and provide them the necessary powers within the legislation to contribute to the development of significant service plans, and co-design and jointly approve locality plans. The MHA and HNZ should support iwi/Māori partnership boards to fulfil their role and offer support to develop capability in the Boards for that purpose.

Diagram of System Operating Model

16. The diagram in Appendix One summarises the System Operating Model generated by the above decisions.

17. The Māori Health Authority has significant roles to improve consideration of hauora Māori at all levels of the system. Cabinet has agreed that legislation will include mechanisms to embed the MHA's role into the health system and enable it to undertake its co-stewardship, commissioning and co-commissioning roles effectively. This will include:

    a. MHA involvement in the development of the Government Policy Statement that sets the overall priorities for the health system, and any national health strategies the Minster determines

    b. co-creation and agreement by the MHA of the NZ Health Plan, that gives effect to the Government Policy Statement

    c. the NZ Health Plan will include a Māori Health Plan that sets out how Health New Zealand will partner with Māori to improve Māori health outcomes. The MHA will approve this as part of the overall Plan.

    d. monitoring roles to monitor the health system's performance for Māori, and to monitor Health NZ's performance against the Māori Health Plan

    e. directly commissioning kaupapa Māori services, other services targeted at Māori, and programmes for Māori workforce development

    f. co-commissioning of national and regional services and programmes through jointly agreeing priorities and commissioning frameworks

    a. working alongside Iwi-Māori Partnership Boards at the locality level to support improvements in primary and community services for Māori, and to ensure that their voice and those of whānau and hapū influence the MHA's functions and priorities.

Implementation arrangements

18. Given the scale of change and the need for certainty, Cabinet has agreed to a fast-paced implementation programme, with:

    - new legislation enacted in April/May 2022 and coming into force on 1 July 2022;
    - interim versions of HNZ and the MHA established as departmental agencies within the Ministry of Health by late 2021;
    - the potential for some functions/capability to be transferred to these entities from the Ministry or DHBs prior to 1 July 2022; and

- all staff, assets and liabilities to transfer to new entities on 1 July 2022.

Decisions being sought from Cabinet and approach to this RIS

19. Most of the above decisions were the subject of a Supplementary Analysis Report in June 2021, and the proposals in the current paper (*Health and Disability System Review – further policy decisions for the Health Reform Bill)* largely relate to the detailed form of the mechanisms, functions, or statutory provisions.

20. However, **the specific institutional form, governance, and accountability arrangements for the MHA were not considered in the Supplementary Analysis Report, and are the major regulatory decision contemplated in the current paper. For this reason, those decisions are the focus of this RIS.**

Engagement with Māori

21. Following the initial Cabinet decisions, the Health Transition Unit in the Department of Prime Minister and Cabinet has been engaging with Māori on the reforms via a steering group led by Tā Mason Durie[5]. Detail of this engagement is set out in **Appendix Two**. The potential form, governance, and accountability arrangements for the MHA have been a key topic of discussion in this engagement over June – July, and the views expressed have directly informed the analysis in the following sections.

[5] Other members of the steering group are Dr Matire Harwood, Tā Mark Solomon, Rahui Papa, Kim Ngārimu, Amohaere Houkamau, and Lisa Tumahai.

What is the problem being assessed?

22. The broad problem of inequitable health outcomes and disparity in key health risk factors between Māori and non-Māori has been tracked for decades. It has been substantively researched and evidenced[6]. For example:

    - on average, Māori live seven years less than non-Māori non-Pacific people, of which 4.4 years for females and 5.0 years for males can be attributed to potentially avoidable causes of death;
    - Māori have a cardiovascular disease mortality rate twice that of non-Māori non-Pacific people, and a similarly higher cancer mortality rate;
    - the infant mortality rate for Māori is 4.7/1000 live births compared with 3.3 for non-Māori non-Pacific;
    - ambulatory sensitive hospitalisations for Māori aged 45-64 are more than twice those of non-Māori non-Pacific/100,000 of population, and Māori utilise 574 acute hospital bed days/1,000 of population annually, compared with 342 for non-Māori non-Pacific; and
    - 31.2% of Māori adults are daily smokers (compared with 11.7% of non-Māori non-Pacific), and 16.9% of Māori children are obese compared with 9.8%.

23. The failure of the Crown to address these disparities and adequately meet its Treaty obligations also impacts on the health of the Māori Crown relationship and the cultural and spiritual wellbeing of Māori.

24. Whilst wider socio-economic factors are the major driver of health inequity, the outcome disparity above can also be attributed to a combination of the following causal factors <u>within</u> the health system:

    a) cognitive bias towards western models of care and service delivery that leads to insufficient quality of care for Māori and culturally unsafe or ineffective services;[7]

    b) a government failure to correct this bias by sufficiently providing for and supporting a te ao Māori perspective and the incorporation of mātauranga Māori in regulatory and operational frameworks for the health sector;

    c) insufficient investment and support for Maori health models, Māori providers and the Māori health workforce; and

    d) insufficient opportunities for Māori to exercise rangatiratanga and mana motuhake over their health at an iwi, hapū, and whānau level, and within the health system.

25. While there are many examples of successful taha Māori or kaupapa Māori services, these are not comprehensively available or enabled by the system as a whole.

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[6] See Table 2.3 of the Final Report of the Health and Disability System Review, sourced from the New Zealand Mortality Collectio: M Walsh and Grey, C, 2019 – The contribution of avoidable mortality to the life expectancy gap in Māori and Pacific populations in New Zealand; Statistics NZ (Infoshare), and Ministry of Health (National Minimum Dataset & New Zealand Health Survey).

[7] For a range of statistics supporting disparity in access and quality of care, refer to https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/Window_2019_web_final.pdf

The specific problem addressed in this RIS and previous efforts to address this

26. Within this broad problem definition, and given the decisions already made by Cabinet, the specific problem to be addressed in Section 2 is **the absence of an institutional mechanism that would respond to the factors in 24(a) and 24(b)** at a national and regional level.

27. In previous reforms (both large and small), a range of approaches have been taken in an attempt to ensure Māori health equity – from representation on boards or in executive roles, to the establishment of separate Māori teams or supplementary commissioners. Today's DHBs similarly take a diversity of approaches, including appointing Māori board members, establishing advisory Iwi-Māori Partnership Boards to seek Māori input on key strategic and policy decisions, and variable investment in kaupapa Māori providers to better reach into Māori whānau and communities. These measures have been insufficient for a range of reasons, including because:

    - the institutional 'weight' of large organisations makes achieving transformational improvement difficult for a small number of Māori-oriented actors inside them;
    - the compounding effects of strategy, policy-making, planning, commissioning and monitoring mean that without clear Māori input at each level, divergence from equity-focused approaches can easily occur;
    - insufficient resourcing and prioritisation decisions have meant funding and resources have not been directed to Māori; and
    - insufficient recognition has been given to tino rangatiratanga and mana motuhake – key aspects of the government's Tiriti o Waitangi obligations – relegating Māori voices outside of the public health system to advisory roles.

28. These points make a strong argument that attempting to provide solely for the Māori perspective within agencies that are primarily accountable to the Crown (DHBs are Crown Agents for the purposes of the Crown Entities Act) is unlikely to solve the problems above.

What objectives are sought in relation to the policy problem?

29. The overarching objectives in relation to the above problem are that:

    - the health system will reinforce Te Tiriti o Waitangi principles and obligations; and
    - all Māori will be able to access a comprehensive range of services that meet their particular needs for staying well.

30. In order to meet these objectives:

    - a Māori voice and perspective will be firmly embedded in the system, with effective and meaningful leadership by Māori and partnership between the Crown and Māori at all levels;
    - the Māori perspective will be jointly responsible for the way that organisations set priorities, design, commission, or deliver services, and monitor outcomes; and
    - taha and kaupapa Māori services and options will be more widely available for Māori communities and embedded as a core part of integrated service arrangements.

Specific objectives for the organisational form of the Māori Health Authority

31. Within the above context, the functions already agreed for the Māori Health Authority will go a long way towards achieving key objectives. Nevertheless, it remains critical that the organisational form, governance and accountability arrangements for the MHA ensure that it can:

    - engage and partner with Māori effectively (in accordance with tikanga) in order to **understand the Māori perspective;**
    - **reflect that perspective meaningfully and efficiently** in strategy and policy work, in the planning, design, and commissioning of services at a national and regional level and in its monitoring and provider/workforce support functions;
    - **partner specifically with Iwi-Māori Partnership Boards** to make the link between the needs and aspirations expressed at the locality level and the planning and commissioning at national and regional levels; and
    - **be clearly accountable to Māori, Ministers and the wider New Zealand public** in relation to the exercise of its functions.

Section 2: Deciding upon an option to address the policy problem

What criteria will be used to compare options to the status quo?

32. Given the objectives above, we have chosen criteria that represent not just the standard considerations for public organisations (cost, public accountability etc.) but also criteria that represent the ability of the organisation to challenge cognitive bias, 'think differently' about how to address the persistent disparities in the system, help the Crown meet its Treaty obligations, and be strongly accountable to Māori:

    a) **Cost and difficulty of implementation** – this includes the fiscal cost, time needed, legislative complexity, and practicality of both the establishment and the ongoing operation of the entity;

    b) **Public financial accountability** – this represents how well the options provide for an essential level of accountability to the NZ public for delivering value for money in public goods and services;

    c) **Reflecting the Treaty partnership and accountability to Māori:**

       The Māori Health Authority is not the Treaty partner for the purpose of health and disability sector, and it does not hold or exercise tino rangatiratanga or mana motuhake – this authority resides with iwi and hapu. But the MHA will be expected to accurately convey the Māori perspective in national and regional level conversations about strategy & policy, service planning and commissioning. It will operate in the space where the exercise of kawanatanga and rangatiratanga overlap, and it needs to make a critical contribution to the Crown meeting its obligations of partnership, active protection, the consideration of options, and the provision of equity.

       As such, this criterion considers how well the organisational form reflects the nature of the Treaty partnership and how accountable the MHA would be to Māori for its representation of the Māori perspective;

    d) **Effectiveness/Ability to innovate from the status quo** – this criterion considers how likely it is that the organisational form will enable the Authority to impact positively on health inequities for Māori, including how well it enables or incentivises thought leadership by the MHA, and innovative approaches to commissioning or service options that will better respond to the unique needs of Māori consumers.

33. Some standard criteria for assessing public organisational form (such as credibility or 'degree of independence') are effectively being considered as part of criterion 'C'.

34. While we have not explicitly weighted these criteria, we expected that failure to achieve any positive score in relation to (b) or (c) would significantly reduce an option's chances of being preferred, and for (b) and (d) to flush out tensions between the Crown's traditional, westernised accountability mechanisms and an organisational form capable of addressing health inequities for Māori.

What scope will options be considered within?

35. The scope of options has been limited by Cabinet's decision to establish the MHA as a statutory entity, which has ruled out the options of establishing the MHA as a Business unit or a Departmental Agency within a Department of the Public Service.

36. This decision was informed by the perspective that a departmental form (with the close ministerial relationship that implies) would not adequately reflect the Treaty relationship, would not empower the MHA to express the Māori perspective in the context of that relationship , and would not provide sufficient accountability to Māori.

Nature of the status quo/counterfactual & the comparison of options

37. When reading the comparison, it is important to bear in mind that the functions proposed for the MHA include:

    - joint development of national strategies with the Ministry and national and regional service plans with Health New Zealand, with the MHA to co-sign or approve before such plans or strategies come into effect (including the NZHP and Locality Plans);
    - lead commissioning of kaupapa Māori health services and other services targeted for Māori (while giving effect to the NZ Health Plan);
    - co-commissioning of other health services accessed by Māori, working jointly with Health New Zealand to develop and approve commissioning plans/priorities;
    - supporting Iwi-Māori Partnership Boards (where required) in the exercise of their functions, and engage with such Boards in its planning and commissioning roles;
    - Māori provider and Māori workforce development;
    - monitoring the performance of HNZ against its objectives for hauora Māori; and
    - monitoring the wider health system's performance for Māori (in partnership with the Ministry of Health).

38. Although a decision has been made to establish a statutory entity, such entities can take a large variety of forms, and a hypothesised version of such an entity that would not be able to deliver the above functions is not meaningful as a counter-factual.

39. **As such, all options assessed are considered capable of delivering the functions above in some form, and are effectively being compared to a status quo where the absence of a Māori Health Authority means that the Crown is not meeting its obligations of partnership with Māori and not being effective in addressing health inequities**.

40. Public financial accountability is assessed against a zero base, because the MHA will be performing new functions or existing functions in a different organisational context. Costs are marginal costs, which have already taken into account the transfer of some capacity from the Māori Health Directorate in the Ministry of Health to the MHA.

What options are being considered?

41. The table in **Appendix Three** sets three options for the form of the organisation, which are defined further by the nature of the key governance and accountability mechanisms that would attach to this form, such as:

    - how Board members would be appointed and removed (i.e. by the Crown or independently);
    - specific reporting and accountability documents required of the organisation;
    - the power of the Crown to input to the organisation's strategic intentions or direct the organisation to act consistently with Crown policy;
    - the collective duties of the Board or organisational employees;
    - any specific obligations/accountabilities to Māori; and
    - the scope of common restrictions such as liability and financial prudence.

42. Generally speaking, the options vary based on how autonomous the entity would be, how responsive it is to Government policy, and how directly accountable it would be to Māori (with all of these elements increasing across Options One to Three. All options would be given effect via the Health Reform Bill.

43. **Option One** is defined entirely by the default provisions for statutory entities under the Crown Entities Act, although it 'batches' the three different types of statutory entity possible under the Act (Crown Agent, Autonomous Crown Entity, Independent Crown Entity). Whilst <u>some</u> of the default provisions in the CEA vary (or can be varied) depending on the sub-type of statutory entity, others do not anticipate this, and the MHA would still undertake its functions within the scheme and purpose of the Crown Entities Act. Te Taura Whiri I Te Reo Māori (the Māori Language Commission) is an example of Option One, being an Autonomous Crown Entity.

44. **Option Two** would see the Bill establish the MHA <u>outside</u> of the scheme and purpose of the Crown Entities Act. It would still utilise most of the key mechanisms in the Act but would modify these in places to explicitly provide for a Māori perspective or more direct accountability to Māori (as set out in **Appendix Three**). For example, this model includes a modified appointment process, with the Minister making appointments in consultation with a standing Māori advisory group.

45. It should be noted that the key modifications in Option Two could be made in the enabling statute, but with the Authority still deemed to be a 'Crown Entity' (subject to the scheme and purpose of the Crown Entities Act) – a kind of intermediate option between One and Two. This option has not been separately analysed because of feedback during engagement with Māori that this would not reflect the nature of the Treaty partnership (the relationship between kāwanatanga and rangatiratanga), and would not be perceived as a sufficient mandate for the MHA to promote equity and the active protection of Māori interests (see row three of the multi-criteria analysis below).

46. **Option Three** amounts to a fully bespoke statutory entity with a greater level of organisational autonomy. Whilst governance and accountability mechanisms could vary widely, we have assumed (for analytical purposes) that the functions and publicly funded nature of the MHA would still require some essential financial prudential requirements and accountability to the public. Many of the assumed features match those of Te Mātāwai under the Māori Language Act 2016.

How do the options compare to the status quo/counterfactual?

	Option One: Statutory Entity under the CEA 2004	Option Two: Statutory entity using modified CEA mechanisms	Option Three: Fully bespoke statutory entity
Cost and difficulty of implementation	- *Quantified marginal costs (and assumptions) for the establishment and operation of a statutory MHA are discussed more fully in the costs and benefits section, but are not expected to vary materially across the three options.* *Whilst there could be slightly less cost associated with corporate structures under Option 3 (should that entity not have to prepare accountability documents with the same level of detail) this could just as easily be offset by a wider scope for external engagement and/or more autonomy in how they undertake their business.* *The bespoke nature of Option 3 could also generate more complexity (& time needed) in the legislative process, which would lengthen the uncertainty risks associated with reforms, but this is not certain enough at this point to vary the overall assessment.* *All three organisational types are assumed to need Governing Boards, and all three would have to deliver the essential functions set out in paragraph 37. We consider these core functions to be the determinative driver of cost for all options.*		
Public financial accountability	++ The core accountability documents under the CEA provide for a high level of transparency about strategic intentions, proposed outputs, and the basis on which the performance of the Authority will be assessed.	++ All the fundamental benefits of the CEA mechanisms would be retained in this option. If anything, we consider that the modified direction powers and input from a standing Māori advisory group would enhance accountability because it would ensure that performance is assessed against outcomes which represent an indigenous perspective on hauora Māori	+ This option could substantially replicate the content requirements of SOIs and SPEs under the CEA., or could use a purchase agreement model, similar to the Crown Funding Agreements for DHBs at present. However, the absence of genuine dialogue between the Crown and the MHA in setting expectations and outputs creates a risk that activities and performance for some functions may not match the expectations of the Government or the wider public. This risks minimising

			the effectiveness of the model, if Ministers are unwilling to commit significant funds due to accountability concerns.
Reflecting the Treaty partnership & accountability to Māori	+ There are several points in the CEA mechanisms which contemplate a dialogue between the entity and the responsible Minister, and nothing would prevent the responsible Minister from consulting the Authority in the exercise of their functions. As noted in **Appendix Three**, Ministerial direction powers under the CEA are (or can effectively be) reduced or removed under the Autonomous and Independent Crown Entity forms. However, other mechanisms in the standard model reflect ministerial control (such as the appointment and removal of Board members by the Minister or Governor General). In addition, the scheme and purpose of the Act is primarily about the accountability of entities to the Crown. **Such an overarching purpose does not recognise the complex inter-relationship between the exercise of kāwanatanga and rangatiratanga that will occur with an MHA that has the extensive functions already agreed.** **This means that an Authority aligned with Option 1 is unlikely to be perceived by Māori as reflecting the Treaty partnership, or as possessing a sufficient mandate to**	++ The legal form and modifications to governance and accountability mechanisms in Option Two are designed to reflect a stronger sense of partnership between the MHA, public health organisations and the Minister, and a stronger accountability to the Standing Māori Advisory Group and the Māori community (including Iwi, hapū, whānau, and hapori Māori). The Standing Māori Advisory Group would not portend to betake the place of the Treaty partner, but its role in influencing the content of the SoI & SPE and acting as a check on the Minister's direction power better reflects the nature of the wider partnership between the Crown and Māori.	+ Whilst the approach in Option Three could provide the MHA with a strong sense of autonomy and accountability to Māori, it would give the Crown little assurance about the capability of Board members to discharge their functions, and no input into the quality and focus of the SOI and SPE or their equivalents (short of amending the establishing statute at a later date to effect this). The planning and co-commissioning functions of the MHA will require close interaction with national priorities and the wider public interest, and the features of this option may limit its ability to reflect a constructive partnership between the Crown and the Authority.

	promote equity and the active protection of Māori interests. This form also makes little provision for the MHA Board to be directly accountable to Māori.		
Effectiveness & ability to innovate from the status quo	+ Impacting positively on health inequities for Māori will require the MHA to challenge existing, westernised models of care and service provision, and the benefits of doing so may not be immediately obvious or quantifiable. This may require innovation and creativity in performance expectations, or sustained faith in outputs that can only be evaluated over the medium term. A Board appointed solely by the Minister, and the absence of a Māori voice alongside the Minister's ultimate power to direct the content of SoI's and SPEs may limit the mandate for the MHA to act in this way.	++ In comparison to Option One, consulting the Standing Māori Advisory Group on appointments would help to ensure Board members are aware of the evolving needs & aspirations of Māori communities and cutting-edge practice in Māori service provision. It would also help to drive an indigenous perspective in the MHA's key accountability documents.	+ Although Option Three could set a strongly innovative environment, the lack of a clear dialogue with the Minister as to outputs creates a risk that efforts would not align with national priorities or the wider public interest, or simply not make progress where progress can most quickly be made.
Overall assessment	+++	+++++	++

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

47. **Option Two – a statutory entity using modified CEA mechanisms - is the preferred option.** This option ensures an essential level of public financial accountability, places the MHA in the strongest possible position to impact on health inequities, and provides the most balanced approach to wider accountability and a constructive relationship between the Crown and the MHA. This option is supported by the Steering Group chaired by Tā Mason Durie, and we consider it the best possible option for inclusion in the Health Reform Bill.

What are the marginal costs and benefits?

General approach

48. Unlike the multi-criterion analysis above, this cost-benefit analysis (CBA) does not attempt to assess relative costs and benefits of different organisational forms (which would be highly speculative and subjective). Rather, it focuses on the likely costs and benefits of the preferred option for the MHA, as compared with the status quo (where no MHA exists). This is similar to the approach taken to the Regulatory Impact Statement for decisions about the organisational form of Taumata Arowai (the drinking water services regulator) in 2019, where the likely benefits of a stand-alone regulator was compared to the status quo of drinking water services being regulated by the Ministry of Health. Nevertheless, we consider that the preferred option is likely to significantly increase the likelihood of the benefits being realised.

49. Even so, assessing costs and benefits for the operation of the MHA is highly complex. While the organisational costs are known with a relatively high level of certainty, benefits turn on a much wider range of dependent variables. Broadly speaking, we expect the following categories of benefit to flow from the functions of the MHA and how it acts within the system:

    - **avoidance of future, fiscal costs** as a result of earlier, more effective interventions (i.e services being more accessible to, more readily taken up by, or more effective for Māori);
    - **gains in health outcomes** deriving from such change (sometimes measurable in terms of QALY - Quality Adjusted Life Years); and
    - **improvements in other outcomes that contribute to overall wellbeing**, such as financial wellbeing, economic productivity and growth, social trust, cultural wellbeing for Māori, and the health of the Māori-Crown relationship (some of these flow from/are associated with the specific health outcome gains discussed above, but some may also derive simply from the more meaningful expression of rangatiratanga or the representation of the Māori perspective by the MHA).

50. However, a comprehensive and definitive approach to CBA is not possible because:

    - we do not have comprehensive data about the attributable QALY gains from greater uptake or effectiveness of the full range of health services for Māori;
    - we do not always have ethnic-specific usage data from which we can isolate the fiscal cost of interventions for Māori;
    - some fiscal cost savings from more effective, initial interventions will be offset by revealing need that is currently unmet, thereby generating additional costs, but this need/relationship is not well understood; and
    - we cannot predict (in a quantifiable way) the total extent to which the operation of the MHA will lead to better designed interventions, or the extent to which such interventions will lead to health outcome gains/fiscal cost savings. This is partly because of unknowable factors such as how much capability the MHA can acquire, or the amenability of existing interventions to better design, but also because we do not yet know the scale of funding that the MHA will be able to access in its 'direct commissioning' of services role (this question will be

determined as part of separate policy decisions on funding, alongside the wider central government budget process for 2022).

51. For these reasons, we have adopted a form of **'reverse analysis'**, which aims to give the best possible sense of how likely benefits are to meet or outweigh costs. We have done this by selecting **four specific areas** where there is major disparity between Māori and non-Māori, and where we can meaningfully quantify the total **potential** benefits (in either improved health outcomes or fiscal cost avoided) from 'equalising' the coverage or effectiveness of particular services between Māori and non-Māori.

52. We have then scaled those benefits to a conservative proportion (20-30%) of the total (representing our working assumption as to **how likely it is that the existence and operation of the MHA** will lead to those outcomes through better informed and designed interventions, **even without additional investment ring fenced for kaupapa Māori services)**.

53. Because these monetised examples relate to only a small number of specific services and outcomes, this gives significant confidence that the **full range** of monetise-able and non-monetise-able benefits would outweigh the organisational costs of the MHA.

54. The following table summarises our overall analysis, which is discussed in more detail under the headings below. The timeframe for cost and benefit streams pre-discounting has been capped at 15 years to match the time period for which we have information about the QALY benefits of better coverage for Māori in breast, cervical, and bowel screening (**Benefits example 1**).

Affected groups *(identify)*	**Comment** *nature of cost or benefit (eg, ongoing, one-off), evidence and assumption (eg, compliance rates), risks.*	**Impact** *$m present value where appropriate, for monetised impacts; high, medium or low for non-monetised impacts.*	**Evidence Certainty** *High, medium, or low, and explain reasoning in comment column.*
Additional costs of the preferred option compared to taking no action			
Establishment and ongoing organisational costs of the Māori Health Authority (borne by Central Government)	Ongoing operating cost (15 years) for the MHA - excludes any commissioning budget that may be ring-fenced for the Authority *(Net present value)* *Short term costs can be relatively well estimated, but there may be some variation over time as we better understand the necessary mode of operating for the MHA and the scale of its commissioning budget*	$282m	Medium
Total monetised costs		$282m	
Non-monetised costs		Nil	

Additional benefits of the preferred option compared to taking no action			
Health system consumers	**Example 1** Health Benefit of more equitable coverage for select cancer screening services for Māori *(Net present value of Quality Adjusted Life Years gained over 15 years, with a **30%** reduction in current equity gap)*	$14 – $79m *(depending on QALY valuation method – see notes below)*	Medium-High
Central Government <u>and</u> Health system consumers *(to the extent that fiscal savings can be reinvested in health outcomes)*	**Example 2** Costs of care avoided from reduced variation in the prevalence of diabetes between Māori & non-Māori *(Net present value of annual cost savings over 15 years from a **20%** reduction in the equity gap).*	$65m	Low – medium *(Evidential certainty is considered lower for examples 2 & 3 because, unlike for cancer screening, we do not have a definitive intervention which, if more equitably accessed, would be certain to improve treatment. However, we consider this uncertainty is offset by the more conservative scaling factor of 20%)*
	Example 3 Costs of care avoided from reduced variation in the prevalence of cardiovascular disease between Māori & non-Māori *(Net present value of annual cost savings over 15 years from a **20%** reduction in the equity gap).*	$27m	
	Example 4 Costs of care avoided from reduced variation in unplanned hospitalisations *(Net present value of annual cost savings over 15 years from a **20%** reduction in the equity gap).*	$191m	Medium
Total monetised benefits		$297m – $362m	Medium
Non-monetised benefits	Improvements in outcomes that contribute to overall wellbeing, such as social trust, productivity, civic governance and partnership, cultural wellbeing for Māori, and the health of the Māori-Crown relationship. *(Many of these benefits are intangible but well accepted domains of wellbeing)*	Low-medium	Low

MHA Organisational Costs

55. The net present value of costs in the table above is based on the ongoing operating and upfront capital funding approved in Budget 2021 for the **organisational costs of the MHA**, shown in the table below. As noted above, these figures exclude any specific commissioning budget for the MHA that may be obtained in future budgets.

$million	*2021/22*	*2022/23*	*2023/24*	*2024/25*	*2025/26 (& outyears)*	*Total Operating (forecast period)*	*Total Capital*
Māori Health Authority	23.119	17.895	28.303	28.679	28.679	97.996	0.150

Assumptions that underpinned the bid

56. s9(2)(f)(iv)

57.

58. We have applied a 20% contingency due to risk and uncertainty, and costs have been discounted to NPV at the Treasury's default rate for regulatory proposals and general social sector projects (5%).

Benefits

59. As discussed above, monetised benefit assessment is based on four examples where there are major disparities between Māori and non-Māori, and where better service design and commissioning by the MHA could result in more effective or equitable uptake of particular services between Māori and non-Māori (and the health or fiscal cost 'avoidance' benefits associated with that change).

60. The methodology and assumptions for these examples are set out below. Note that although there will be some overlap between the costs of care avoided for cardiovascular disease and diabetes (Examples 2 and 3) and those for unplanned hospitalisations in Example 4, we do not consider this invalidates the examples for use in a reverse analysis, and any duplication will arguably be offset by the conservative assumptions used for scaling all benefits.

Example One: Health benefit of more equitable coverage for select cancer screening services

61. The benefits in this example are derived from analysis commissioned by the Health Transition Unit and based on a number of studies of the impact of cancer screening in

New Zealand and overseas[8]. Table 1 shows a summary of estimated outcomes from improving equity in screening rates between Māori and European/Other peoples for breast, cervical and bowel cancer. The table is based on a 30% reduction in the current equity gap in screening between Māori and non-Māori.

62. Outcomes are based on lifetime reductions (avoided cancer cases and deaths, and life-years and QALYs gained). This is because screening a person today may prevent a cancer case in the future, with the benefits accruing over the remaining life of that person. We provide these lifetime outcomes based on one, five and fifteen years of screening with improved equity[9] for Māori.

63. Population numbers screened are rounded to the nearest 100, cancer cases and deaths to the nearest 5, life-years/QALYs gained to the nearest 10 and value of life-years and QALYs to the nearest $100,000. Breast and bowel screening life-years/QALYs and the monetised values of these are discounted at a rate of 3.5% per annum, while the results for cervical screening are discounted at 3.0% per annum due to a difference in the discounting rate used in the original source studies.

64. The range provided for the value of QALYs gained reflects two conceptually different approaches. The lower end of the range is generated using the Tsy's 2021 CBAx valuation for a QALY ($32,258), which is derived from Pharmac's 2019/20 threshold (QALY/$million spent) for funded proposals. This represents a public-sector willingness to pay/revealed preference approach (what the government is currently willing to spend on medical intervention in one area - pharmaceuticals).

65. The upper end of the range values QALYs at three times NZ GDP per capita ($189,000), which is the outer limit of 'cost-effectiveness' under the WHO-CHOICE initiative[10]. Valuations such as the WHO-CHOICE approach take into account the productive capacity of individuals, the social impact of illness, and even the 'experience' of being ill. Value coefficients for such approaches in international literature can be as much as five – ten times higher than the CBAx coefficient. For this reason, and given the significant international debate about such methodologies, we think it legitimate and important to reflect this valuation range in the RIS.

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[8] See: Pharoah, P. D., Sewell, B., Fitzsimmons, D., Bennett, H. S., & Pashayan, N. (2013). Cost effectiveness of the NHS breast screening programme: life table model. Bmj, 346; https://www.nsu.govt.nz/system/files/resources/bsnzmortcohcceval_final7_8_dec.pdf; Hider, P, Dempster-Rivett, K., Williman, J., Dempster-Rivett, M., Sadler, L., McLeod, M., & Sykes, P. (2018): A review of cervical cancer occurrences in New Zealand 2008-2012. NZ Med J, 131, 53-63; Lew, J. B., Simms, K., Smith, M., Lewis, H., Neal, H., & Canfell, K. (2016): Effectiveness modelling and economic evaluation of primary HPV screening for cervical cancer prevention in New Zealand. PLoS One, 11(5), e0151619; Chesson, H. W., Meites, E., Ekwueme, D. U., Saraiya, M., & Markowitz, L. E. (2018): Cost-effectiveness of nonavalent HPV vaccination among males aged 22 through 26 years in the United States. Vaccine, 36(29), 4362-4368; Te Aho o Te Kahu. 2021. *He Pūrongo Mate Pukupuku o Aotearoa 2020, The State of Cancer in New Zealand 2020.* Wellington: Te Aho o Te Kahu; Cancer Control Agency, and Love, T., Poynton, M. & Swansson, J. 2016. *The cost effectiveness of bowel cancer screening in New Zealand: a cost-utility analysis based on pilot results.*

[9] We note that having equal screening rates may not be considered an 'equitable' outcome. Given the higher prevalence rate of some cancers in Māori, a higher screening rate may be required to achieve equitable health outcomes. True equity of screening is highly dependent on many factors, including relative incidence, relative treatment and prognosis and co-morbidities.

[10] The WHO CHOICE programme provides frameworks for countries to use in evaluating health investments.

Table 1 Summary of outcomes from improved equity in selected screening programmes

30% reduction in equity gap		One year	Five years	Fifteen Years
Breast	Average number of additional women with adequate screening	2,700		
	Number of cases identified	10	50	155
	Reduction in breast cancer deaths	0	5	10
	Discounted life-years gained	0	10	40
	Value of life-years gained	Negligible - $0.6M	$0.3M - $2.8M	$1.3M - $7.2M
Cervical	Average number of additional women with adequate screening	7,000		
	Number of cancer cases prevented	5	15	40
	Deaths prevented	0	5	10
	QALYs gained	10	70	170
	Value of QALYs gained	$0.3M - $2.7M	$2.3M - $12.6M	$5.5M - $32.2M
Bowel	Average number of additional people with adequate screening	2,100		
	Number of cancer cases prevented	5	25	75
	Deaths prevented	5	20	65
	QALYs gained	20	80	210
	Value of QALYs gained	$0.6M - $3.3M	$2.6M - $15.5M	$6.8M - $39.5M

Example Two: Costs of care avoided for Diabetes

66. The benefits in this example derive from an analysis of the treatment costs that would be avoided if better interventions designed and commissioned by the MHA reduced the difference in the prevalence of diabetes between the Māori and non-Māori populations. This analysis adopted the following methodology:

- differential prevalence rates of diabetes were obtained for Māori & non-Māori 15 years and over (5.6% compared with 2.8%)[11];

[11] National Health Collection data, Ministry of Health, 2013-14

- this differential was scaled with data on the Māori population[12] to give an 'excess' of 16,592.8 cases of diabetes for Māori over non-Māori;
- the current annual treatment cost of these excess cases was 'valued' at $82.4m using the Treasury's 2021 CBAx variable for 'total average, annual health care cost for person with diabetes' ($4,968 per person); and
- 20% of this cost stream ($16.4m p.a) was discounted to present value (at 5% p.a) over a period of 15 years, but no cost avoidance was relied on in the first ten years given the time needed for the MHA to become established and impact on these outcomes through better service design, commissioning, and influence.

67. It is important to note that this figure is likely to be an underestimate of the costs avoided, because treatment cost for Māori is likely to be much greater than the average due to the higher incidence of more severe consequences or complications associated with diabetes for Māori. It is also important to note that for this, and the following examples, this analysis includes only treatment costs, and not the wider costs associated with diabetes, such as employment difficulties faced by dialysis patients who must attend treatment for several hours several times a week.

Example Three: Costs of care avoided for Cardiovascular disease

68. The benefits in this example derive from an analysis of the treatment costs that would be avoided if better interventions designed & commissioned by the MHA (or co-commissioned with HNZ) reduced the difference in the prevalence of cardiovascular disease between the Māori and non-Māori populations. This analysis adopted the following methodology:

- differential prevalence rates of cardiovascular disease hospitalisation were obtained for Māori & non-Māori 35 years and over (3186.4 cases/100k compared with 1936.5 cases/100k)[13];
- this differential was scaled with data on the Māori population[14] to give an 'excess' of 3944 cases of cardiovascular disease hospitalisation for Māori over non-Māori;
- the current annual treatment cost of these excess cases was 'valued' at $34.1m using the Treasury's 2021 CBAx variable for 'total average, annual health care cost for person with cardiovascular disease' ($8,653 per person); this will be an underestimate, as the cost of treatment for a patient requiring hospitalisation will be higher than the average cost, and
- 20% of this cost stream ($6.8m p.a) was discounted to present value (at 5% p.a) over a period of 15 years. No cost avoidance was relied on in the first ten years of operation given the time needed for the MHA to become established and impact on these outcomes through better service design, commissioning, and influence.

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[12] Stats NZ, 2020

[13] National Health Collection data, Ministry of Health, 2012-14

[14] Stats NZ, 2020

Example Four: Costs of care avoided for unplanned hospitalisation

69. This example considers the fiscal impacts of reducing variation across hospital services for unplanned hospitalisations for Māori. It is an adaptation of the analysis provided in Appendix Two of the Supplementary Analysis Report completed for the Cabinet decisions made in March about the general package of reforms, which did not differentiate as to ethnicity.

70. Activity Data were extracted from the National Minimum Dataset (NMDS) for the financial year 2018/19[15]. These data were then classified into key groupings of activity – important for understanding the split of how activity is funded and to support quantification of the impacts on future costs of Tier 2 service delivery. The following table provides the split of NMDS by key group for Māori, including estimated costs based on WIES and national prices in 2018/19.

Table 2: 2018/19 NMDS activity and cost based on National Price by group for Māori

Group	Discharges	Bed-days	WIES	Cost based on National Price[16]
Publicly funded casemix-included	169,779	369,598	149,898.4	$760M
Publicly funded casemix-excluded[17]	7,557	127,941	21,611.5	$110M
Publicly funded purchase unit funded[18]	13,203	34,313	11,771.2	$43M
ACC funded	1,230	7,661	2,050.0	$10M
Overseas ineligible	116	57	52.5	~$0M
Total	191,885	539,570	185,383.6	$923M

Population data

71. To estimate the trajectory of demand and therefore estimated costs under current models of care, we use the demographic projections provided to the Ministry of Health by Statistics New Zealand on an annual basis. These projections are on an age, ethnicity (Prioritised Level 1 Ethnicity, with Asian grouped with Other ethnicities), and NZ Deprivation Index 2013 quintile basis and projects the population of each DHB's domiciled population by calendar and financial year out to 2042/43.

Adjusting for reducing rates of unplanned hospitalisation for Māori

[15] This avoids the impacts of COVID-19 on care patterns and delivery.

[16] $5068.12 per WIES in 2018/19. It is noted that in 2020/21 a significant uplift in price occurred with a further uplift planned for 2021/22. These uplifts are intended to align pricing with efficient service delivery costs as per the National Pricing Programme's technical working group advice.

[17] Costs for casemix-excluded activity are estimated based on the National Price per WIES.

[18] Costs for purchase unit funded activity are a mixture of casemix-excluded activity where there is a National Price on a per event basis, and estimated costs based on the National Price per WIES for activity such as Solid Organ Transplantation which does have a purchase unit but is not funded on a per event basis.

72. Here unplanned hospitalisation rates are age and deprivation quintile standardised (i.e., adjusting for the impacts of differing age and socioeconomic deprivation structures which correlate with or can drive demand for care). The following graph highlights the variation in unplanned hospitalisation rates for Māori across DHBs (based on DHB of Domicile).

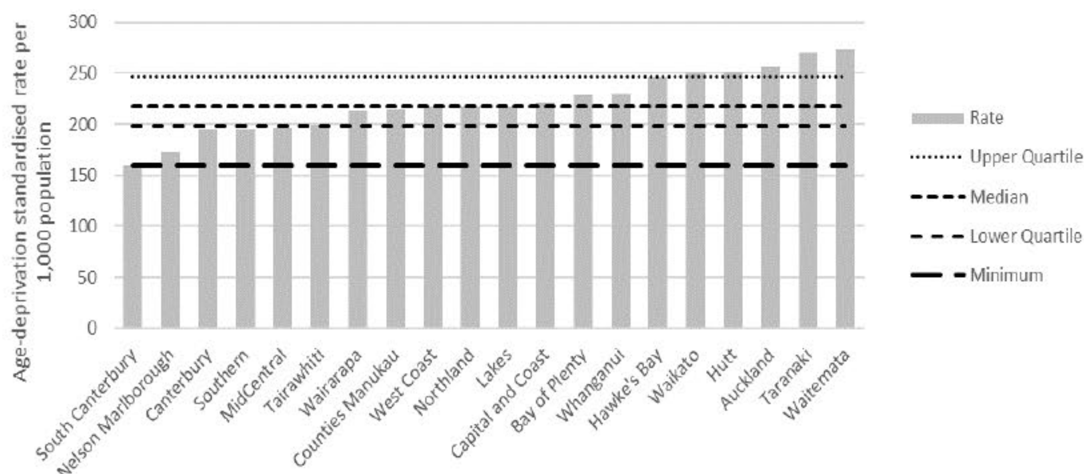


Figure 1: Unplanned hospitalisation rates for Māori by DHB of Domicile, standardised for age and deprivation quintile

73. To estimate the impact of reduced variation in unplanned discharges, rates were reduced to the lower quartile, a 14.5% decrease over a 5-year period.

Table 3: Yearly reductions in events, bed-days, and WIES and cost savings from reduced unplanned admissions for Māori[19]

	2018/19	2019/20	2020/21	2021/22	2022/23
Cumulative % reduction	2.9%	5.8%	8.7%	11.6%	14.5%
Yearly reduction in events	5,547	5,672	5,816	5,940	6,047
Yearly reduction in bed-days	15,551	15,901	16,305	16,653	16,954
Yearly reduction in WIES	5,353	5,473	5,612	5,732	5,836

[19] In contrast to the SAR Appendix 2, this impact is based on all unplanned hospitalisations and does not separately consider impact of reduced rates of readmission.

Yearly cost saving	**$27M**	**$27M**	**$28M**	**$29M**	**$29M**

74. It is important to note that the savings in the above table are cumulative. To generate a sense of the potential benefits from the MHA for the purposes of this RIS, we have used the above analysis to hypothesise a 15-year stream of annual cost savings, starting at 2021/22, but with actual savings not kicking in until 2023/24 (as for examples 2 & 3). We have used the cumulative reduction path shown in the table above for this period, with annual cost savings at $27m in 2023/24, $54m in 24/25, $82m in 25/26, $111m in 26/27, and topping out at $140m in 2027/28 for the next eight years.

75. We expect this to generate an underestimate of the stream of cost savings, given that prices and demand are both likely to have risen since 2018/19, and to continue to rise throughout the 15-year period.

76. As for other examples, we have then applied a 20% multiplier to represent the probability that the operation of the MHA leads or contributes to the changes in service design/efficacy needed to achieve these cost reductions and discounted this reduced stream of savings at 5%.

Section 3: Delivering an option

How will the new arrangements be implemented?

78. As with any major reform programme, there are risks in establishing new publicly funded entities, including the need for clarity of function and purpose within the organisation, the time taken to build capability and onboard staff, and the need to quickly establish operating models and frameworks for the organisations.

Interim Entity processes & enabling legislation

79. The establishment of the Māori Health Authority has and is being actively managed by the Health Transition Unit in the Department of Prime Minister and Cabinet. A steering group led by Tā Mason Durie considered and provided advice on the form, governance and accountability proposals (amongst other hauora Māori components of the reforms).
80. An interim Māori Health Authority (alongside an interim Health New Zealand) will be established as a Departmental Agency in the Ministry of Health by late 2021, with an advisory committee (rather than a Board as such), the members of which will have been shortlisted and assessed by the Steering Group and appointed by Cabinet under the usual 'appointments and honours' process.
81. A dedicated workstream of the reforms is considering which functions could and should transfer from the Ministry of Health to the interim entities (including the MHA) ahead of these taking their final organisational form at 1 July 2022.
82. As noted in Section One, one of the key objectives in the reforms is greater cohesion and clarity of functions across the system, and the specification of roles, instruments, and responsibilities in new Health and Disability Legislation will provide significant certainty. The Health Reform Bill will be introduced to the House in late 2021 in order to provide a strong indication to the interim entities of the planning, governance, and accountability frameworks in which they will be working.

Early scoping of key instruments and operational choices

83. The Transition Unit has also begun preliminary analysis for the interim versions of key planning documents such as the Government Policy Statement and the New Zealand Health Plan, is scoping the potential nature and functionality of locality networks, and is reaching out for early conversations with Iwi-Māori Partnership Boards. The Unit will look to share this scoping work with the interim entities as soon as possible with a view to giving them a 'head start' in understanding their specific responsibilities.

Communications and engagement

84. The Transition Unit has dedicated public communications and stakeholder engagement resources and is conducting an active programme of stakeholder engagement at multiple levels (existing DHB Governance, workforce leaders, sector groups). The Unit will continue to communicate key decisions about reform over the next 10-12 months. From September 2022, responsibility for embedding the reforms will pass to the Ministry of Health in its strengthened role as system steward.

How will the new arrangements be monitored, evaluated, and reviewed?

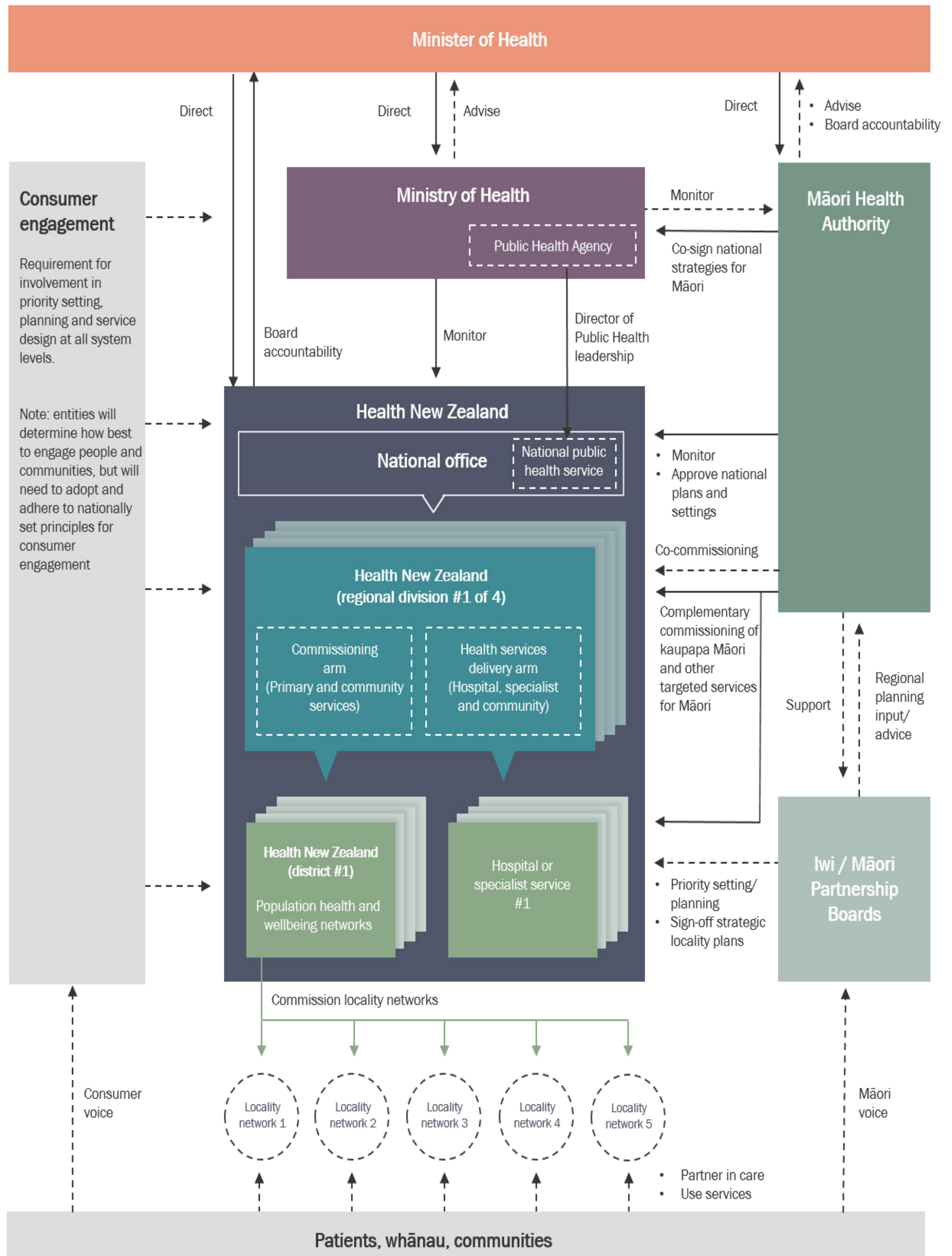
Monitoring the activity & operation of the MHA itself

85. The MHA itself will need a statutory monitoring arrangement similar to that provided for Crown Entities under s27A of the Crown Entities Act, and this will be set out in more detail in the Health Reform Bill.

Wider monitoring as part of system performance & specific review of reforms

86. The efficacy of the reforms as a package (including the impact of the MHA) will initially be assessed through the Ministry of Health's monitoring of system performance. The MHA will partner with the Ministry to ensure that monitoring of system performance reflects the needs and perspective of Māori. Preliminary discussions have begun as to how these roles will interact with Te Puni Kokiri's current statutory monitoring functions in relation to outcomes for Māori.
87. As noted above, the MHA will also have a specific role in monitoring the commissioning and performance of HNZ against its Māori Health Plan in relation to services accessed by Māori.
88. In addition to routine stewardship, it is intended that legislation will require a formal review of the new arrangements after five years, in accordance with usual practice. Early results should be available within that time, in particular figures on changes in unwarranted variation, such as the admission and length of stay figures. The review will provide an opportunity to ensure system arrangements are working as intended and amend planning and accountability documents or legislation, if required.
89. It is unlikely that results of change will be clear any sooner than five years.

APPENDIX ONE: Illustration of proposed health system operating model



APPENDIX TWO: Summary of engagement with Māori since March 2021

- The Transition Unit has engaged extensively with Māori over 2021. This has included the Iwi Leaders Forum, and WAI 2575 claimants. It has also included Māori health and disability providers, both national and regional. A series of regional hui and forums were held, as set out below:

Date	Location	Kaupapa
22 April 23 April	Auckland Hamilton	Northern Region Roadshow Hui, Waikato DHB staff Waikato-Tainui
27 – 28 May	Dunedin	Hui Whakaoranga
1 June 2 June 3 June	Virtual hui Dunedin (Virtual hui) Virtual hui Virtual hui Virtual Hui Virtual Hui	Webinar (50max) Iwi Partner Boards Webinar Māori W/force EAG Waikato Partnership Webinar
8 June 9 June 10 June 11 June	Christchurch Counties Manukau Waitangi Waitangi	Roadshow hui Roadshow hui, Iwi Partner Board Hui Whakaoranga Iwi Partner Boards
15 June 16 June 17 June	Rotorua Hawkes Bay Whanganui Taranaki	Hui Whakaoranga Iwi Partnership Roadshow hui Roadshow hui
22 June 26 June	Virtual hui Wellington	Te Roopu Urutā NZ Maori Council
1 July	Virtual	Tumu Whakarae
5 July 7 July	Whakatane Virtual hui	Iwi Partnership hui, Māori Providers Iwi Partners (Kotui Hauora – Northern DHB's)
12 July 13 July 1 July 15 July	Virtual Palmerston North Virtual Wellington	Central Region hui Midcentral hui Taranaki IMPB Cap Coast/ Hutt Partnership Board

19 July	Virtual Hui	Southern region hui
27 July 28 July	Virtual Wellington	Tristram Ingham (Tangata whaikaha) Māori Mental Health
2 August 5 August	Wellington Tumu Whakarae	CapCoast Māori staff & providers National hui
9 August 12 August	Wellington Wellington	Māori Provider Reference Group PSA Māori team
16 August	Wellington	ADHB Maori Board members
24 August 25 August	Virtual Virtual Virtual	Mid-central IMPB Māori Workforce Advisory Group Wairarapa IMPB

Key themes that emerged included:

- In general, the response from Māori has been one of cautious optimism, with impressions becoming more favourable as more detail of proposals emerged. Key themes included:

Enabling tino rangatiratanga and Tiriti partnership

- Ensuring tino rangatiratanga and Tiriti partnership is explicitly articulated at all levels of the system, including at the Ministerial level; and
- Queries as to what this expression looks like in different regions, and what the 'levers' for each region are.

Accountabilities

- The system must be accountable to Māori through an independent channel, not just through the Crown (e.g. TPK, Te Arawhiti); and
- Accountability should be centred around Te Ao Māori principles and the most vulnerable in the current health system (e.g., pēpi, takatāpui, tāngata whaikaha, transgender, elderly, etc.)

Funding

- Consistent concerns were raised that the dedicated amount of Māori funding must be sufficient to create substantial changes in Māori health outcomes;
- Under-resourcing, workforce shortages, work capability, and patient capacity were all common issues for hauora Māori and Iwi providers;
- There was a desire to see significant changes for Māori-led providers in the future; and
- There needs to be assurance that all services will use their funding to better look after Māori.

Transition and priority-setting

- It will be important not to lose priority and focus on the inequities in hauora Māori throughout the transition phase; and
- DHBs need to be supported to achieve the aspirations and ambitions of the new system throughout the transition so as not to fall behind on equity targets.

IMPB resourcing, decision-making and commissioning

- With the substantial increase in workload for IMPBs, funding, resourcing and support needs to be significantly upgraded too;
- Many were concerned about the dedicated resourcing for IMPBs due to the current underfunding and relationships with District Health Boards;
- Locality decision-making must be viewed as having as much validity and power as regional and national voice, considering that the locality level primarily represents the community and their needs; and
- Many attendees expressed concern about the current working relationships between IMPBs and locality commissioners. Improved ways of working and best practice from the mainstream system that embrace whakaaro Māori must be embraced in the new system.

APPENDIX THREE: Options for the form, governance, and accountability of the Māori Health Authority

Key Governance & accountability mechanisms	Option One: Statutory Entity under the CEA 2004	Option Two: Statutory entity using modified CEA mechanisms (Preferred Option)	Option Three: Fully bespoke statutory entity
	MHA is one of the statutory entity forms provided for under the CEA (Crown Agent, Autonomous Crown Entity, or Independent Crown Entity. This can be either following the legislative defaults or with modifications similar to those in option 2. Status, powers, and accountability requirements are generally proportional to the level of autonomy anticipated, with defaults specified in the CEA. For the purpose of simplifying the comparison the description below represents the default form.	*MHA would take a form which utilises many of the fundamental features & accountability concepts in the CEA, but does so in a way that more explicitly acknowledges the ongoing relationship between kāwanatanga and rangatiratanga and the accountability of the MHA to Iwi, hapū, whānau and hapori. The Authority would sit outside the scheme and purpose of the CEA. [Changes from Option 1]*	*MHA would take the form of a fully bespoke statutory body with a greater level of organisational autonomy. Governance and accountability mechanisms could vary widely, but we have assumed that the functions and publicly funded nature of the MHA require some essential financial prudence and accountability to the public.* ***Many of the assumed features are drawn from the statutory provisions for Te Mātāwai under the Māori Language Act.*** *[Changes from 1 & 2]*
Board appointments & removals	Members appointed/removed by responsible Minister or Governor General (depending on exact form)	Members appointed/removed by responsible Minister in consultation with a permanent, standing Māori Advisory Group constituted under new Health & Disability Legislation	Members could be appointed/removed independently of the Crown (although Crown could influence selection criteria in the design of the statute or hold minority appointment rights)
Public reporting & accountability documents required	• Statement of Intent (SOI), Statement of Performance Expectations including forecast financial statements (SPE), and Annual report (including statement of performance, financial statements, statement of responsibility & audit report) in form prescribed in CEA 2004 • Minister presents to House of Representatives	Same as Option One but with revised powers for ministerial intervention in the content of SOI and SPE (see below). SOI & SPE requirements may be substantively met by contents of New Zealand Health Plan Minister would have power to appoint a monitor, in line with section 27A of the CEA	Significant public funding of organisation would still require planning and reporting documents similar in content to those under CEA. A Purchase Agreement jointly agreed with a relevant Minister could be used to facilitate specific public accountability in the absence of Ministerial direction powers, or public accountability documents similar to those under the CEA (see below)
Power of Crown to intervene in SOI/SPE or direct consistency with Govt Policy	• Responsible Minister may require new statement of intent at any time, or give directions to Crown entities about the content of SOIs or SPEs (other than forecast financial statements) • Responsible Minister may direct Crown Agents to give effect to Government Policy, and Autonomous Crown entities to have regard to Government Policy except for functions that have been specified as statutorily independent	• Responsible Minister may give directions on content of SOI & SPE in consultation with the standing Māori Advisory Group • Responsible Minister may direct Authority to give effect to Government Policy in consultation with standing Māori Advisory Group	Crown would <u>not</u> be able to direct content of SoI or SPE or direct consistency with government policy at an organisational level (although statute could still provide powers for Minister to request information or undertake a review of the Authority) NB: The MHA would still be required to give effect to the NZHP in exercising its functions
Collective duties	Board members must ensure Entity acts in a manner consistent w SOI + SPE and performs functions: • efficiently & effectively; • in a financially responsible manner; • consistent with spirit of the public service; and • in collaboration with other entities.	Similar to Option One, but could require the organisation to act in a manner consistent with tikanga/te ao Māori. Also potential to link these duties to proposed NZ Health Charter	Likely to include components of both Options One and Two, but would not be required to act in the spirit of the public service
Specific legal obligations to engage Māori	None. Engagement obligations guided by general duty to act/perform functions consistently with SOI/SPE and act in spirit of public service	Specific statutory obligations to engage with and have regard to iwi, hapū, whānau, and hapori Māori views in relation to key functions, and to report back on actions taken as a result of that engagement	Could include the same or similar obligations to Option Two, although specific obligations may be considered unnecessary if organisation is entirely & fully accountable to Māori through Board appointments
Liability	General restrictions on liability if acting in good faith	Same as Option One	Assumed to be the same as Option One

Financial restrictions	No borrowing, financial products, derivatives etc	Same as Option One	Assumed to be the same as Option One given the fact that the organisation is still commissioning public services