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Committee Secretariat
Pae Ora Legislation Committee
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Dear Committee Members

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide feedback on the Pae Ora (Health Futures) Bill (the Bill).

ACEM is the peak body for emergency medicine in New Zealand and Australia and has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for ensuring the advancement of emergency medicine in Emergency Departments (EDs) across New Zealand and Australia, as well as the training of emergency physicians in these regions.

ACEM acknowledges the complexity of the task that the New Zealand Government is currently undertaking, and that major reforms of the governance of the health system have the potential to generate both significant improvements and create unforeseen risks. It is essential that te Tiriti is central to this process and that Māori communities have clear, legally enforceable representation and authority to make decisions as a result of these changes.

In providing this response, ACEM also acknowledges that the functioning of the new health entities is not solely dependent on the Bill, but that the reform process will continue as Health New Zealand (HNZ) and the Māori Health Authority (MHA) develop their structures and leadership.

As such this submission will focus on the structure and the framework in which the new entities will operate, including defining their primary functions. From the perspective of ACEM, the relevant most sections are in Part 2 and our response will focus there.

1. Subpart 2 – Health New Zealand

1.1 Board of Health New Zealand

Page 11, Section 12 (3) states the relevant knowledge and expertise that the Minister must be satisfied that the board collectively has knowledge of, and experience and expertise in. These are currently listed as te Tiriti o Waitangi, public funding and provision of services, public sector governance and financial management.

There is currently no requirement for the board to have any knowledge and expertise in the health system. Given that the Minister must appoint between five and eight members, it is a missed opportunity to not specify a need for the board to be inclusive of knowledge and expertise in the health system.

Recommendation: add 12 (3) (e) health system governance and processes.

The legislation does not set out a process for the assessment of the expertise of board members but refers to the Crown Entities Act (Sections 28 and 29) which broadly requires the Minister to only appoint qualified people.

It is important that this process is taken in a transparent and structured manner.

Recommendation: In the Bill, or in subsequent regulations, a transparent process for considering appointments of HNZ board members is publicly described.

The chairperson of the MHA (or nominated co-chair) will be a member of the HNZ board, with voting rights, which is vitally important. However, under the legislation, it does not appear that there is a requirement for this person to be Māori (see 2.2 for more information).

1.2 Functions of Health New Zealand

Page 12, Section 14 (1) lists the 17 proposed functions of HNZ. As one of the two primary health entities in New Zealand, HNZ will responsibility for managing a vast workforce, spanning a large range of diverse workplaces. However, there is no mention of workforce monitoring or management in these functions. MHA has a function to improve the capacity and capability of Māori health providers and workforce.

Recommendation: the Committee should consider the role that HNZ will play in managing a large proportion of the health workforce, with a focus on its role in building and supporting equitable access to health care across New Zealand.

2. Subpart 3 – Māori Health Authority

2.1 Objectives and functions of Māori Health Authority

In the objectives – section 18 (b) - the MHA will design and arrange services, whereas the relevant clause for HNZ - section 13 (a) the delivery of services is included. Given that one of the functions of the MHA is to own and operate services [Section 19 (1) (a)], it is unclear why there is a discrepancy. The previous clause references service delivery, but only in terms of ensuring that it responds the aspirations of Māori people.

Recommendation: change 18 (b) to say design, arrange and deliver services

2.2 Māori Health Authority board

There is no explicit requirement in the legislation for any of the MHA board members to be Māori themselves. When appointing board members, the Minister must consult with the Hauora Māori advisory committee, but is not bound by their recommendations. While we note the intent in the legislation and that in practice it would be unlikely for the Minister of the day to not appoint at least some Māori people to the board, it remains a risk that the legislation doesn't specify the importance of this.

Recommendation: In the Bill, or in subsequent regulations, a transparent process for ensuring Māori representation on the MHA board is publicly described.

3. Subpart 5 – Key Health Documents

3.1 Strategies

Page 18, Section 29 of the Bill sets out a requirement for six different documents and strategies to be developed and maintained:

- Government Policy Statement
- New Zealand Health Strategy
- Hauora Māori Strategy

- Pacific Health Strategy
- Disability Health Strategy
- New Zealand Health Plan

Section 43 requires all health entities to have regard for these strategies when performing their functions or duties.

ACEM supports the development of these strategies but is concerned about how they will intersect in both the planning and implementation stages. There will need to be a high degree of coordination between the groups responsible for developing them, with ongoing implementation support provided to local services.

Recommendation: Section 29 (1) be updated to include a statement on health strategies and plans having regard for one another in their development and implementation.

3.2 New Zealand Health Charter

Section 50 requires the Minister to determine a health charter which will provide common values, principles, and behaviours to guide health entities and their workers.

The charter does not have a requirement to consider the responsibilities that health system users have towards health care workers, and this is a missed opportunity to promote safe work environments.

Recommendation: That the New Zealand Health Charter include information about the common values, principles, and behaviours to guide health system users while interacting with services and staff.

4. Further Matters

4.1 Te Tiriti o Waitangi

HNZ is required to design, arrange, and deliver services to achieve the purpose of this Act in accordance with the health system principles, with one of the purposes of the Act to achieve equity by reducing health disparities among New Zealand's population groups, in particular for Māori. This will require the health service to actively address and eliminate institutional racism, including by ensuring that all policies and practices at all levels are reviewed to ensure outcome will not advantage non-Māori over Māori, or not advantage ethnically European New Zealanders & immigrants over those of colour.

The MHA should have a role in identifying and advocating on interventions or decisions from HNZ that may privilege non-Māori people. Where these are identified, there should be a formal process to escalate these policy or service delivery decisions through the dispute resolution process, as per Subpart 4 – Disputes. This would mean the MHA could veto the implementation of policies and actions that do not result in equitable, antiracist, culturally safe care, while the dispute is resolved.

Recommendation: The MHA should have the power to instigate a veto or pause on the implementation of policies and actions by HNZ that would impact on health equity for Māori people, with a clear dispute resolution process.

4.2 A workforce that delivers culturally safe care

The MHA will have a function of designing and delivering programmes for the purpose of improving the capacity and capability of Māori health providers and the Māori health workforce. However, it is important that Health New Zealand plays a role in supporting this function, by contributing to the training & retention of Māori health care workers. While the MHA will be the lead organisation in developing this workforce, as the largest employer of health care workers, HNZ should have targets in order that the service providers

better match the community they serve. Connected to this, both organisations will have an important role in ensuring that culturally safe care is provided.

Recommendation: That HNZ have a clear role in promoting opportunities for the Māori workforce, with reference to the MHA's leadership role.

Recommendation: That HNZ have a function relating to the provision of culturally appropriate care for all New Zealanders.

Thank you again for the opportunity to provide feedback to this consultation. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Jesse Dean, General Manager, Policy and Regional Engagement (jesse.dean@acem.org.au; +61 3 9320 0444).

Yours sincerely

Dr Kate Allan
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