Taituarā
Local Government Professionals Aotearoa

Submission to the Pae Ora Legislation Committee regarding the Pae Ora (Healthy Futures) Bill

December 2021

What is Taituarā?

Taituarā — Local Government Professionals Aotearoa thanks the Pae Ora Legislation Committee (the Committee) for the opportunity to submit on the Pae Ora (Healthy Futures) Bill (the Bill).

Taituarā — Local Government Professionals Aotearoa thanks (formerly the NZ Society of Local Government Managers) is an incorporated society of approximately 950 members[1] drawn from local government Chief Executives, senior managers, and council staff with significant policy or operational responsibilities. We are an apolitical organisation. Our contribution lies in our wealth of knowledge of the local government sector and of the technical, practical, and managerial implications of legislation.

Our vision is:

> *Professional local government management, leading staff and enabling communities to shape their future.*

Our primary role is to help local authorities perform their roles and responsibilities as effectively and efficiently as possible. We have an interest in all aspects of the management of local authorities from the provision of advice to elected members, to the planning and delivery of services, to the less glamorous but equally important supporting activities such as election management and the collection of rates.

Our recommendations fall into two categories. The first category focusses on those matters of direct concern to local communities and local authorities. The second raises some issues and concerns that are more from the perspective of good legislative design.

Taituarā is an officer organisation not a political one. Our role is to ensure that policy decisions can be implemented in a way that best delivers for local communities.

The Role of Local Government in Health

Some members of the Committee may be wondering why a local government sector organisation is submitting on a health bill. Local authorities are not charged with the direct delivery of health services such as hospital based secondary care services or primary care services such as general practice or pharmaceuticals.

This is to take an overly narrow, functionalist view of the local government sector and its role in the governance of New Zealand. Local Councils have a long history in promoting the public health and wellbeing of their communities directly through

[1] As of 30 October 2021

their provision of services and implementation of a wide range of regulations that influence health outcomes. Indeed, we say local government and central government are partners in promoting the wellbeing of New Zealand. Parliament recognised this in 2019 when it amended the purpose of local government to read:

"(a) to enable democratic local decision-making and action by, and on behalf of, communities; and

(b) to promote the social, economic, environmental, and cultural well-being of communities in the present and for the future."[2]

Health outcomes clearly contribute to community wellbeing in many ways. The impacts of health policies set nationally, or investment decisions made by the outgoing District Health Boards are felt at the local level. For example, issues in the mental health system or with addiction services manifest themselves in increases in crime, rough sleeping/homelessness, and the like.

It should therefore be no surprise that many local authorities have included outcomes relating to healthy communities amongst their statements of strategic objectives termed 'community outcomes' that form the front end of their long-term plans and guide allocation of local resources towards community wellbeing.

And this without a role in the delivery of what the Committee would recognise as front-line health services. So how then do local authorities influence health outcomes at local levels?

- The delivery of a number of 'core' services is done with a health outcome (among others) as its purpose. Most obviously in the provision of the three waters services – safe drinking water and safe, secure treatment and disposal of wastewater. The rationale for three waters reform is to place the provision of these services to meet increased standards in a financially sustainable way, but local councils still have a vested interest on behalf of their communities in health-related outcomes that derive for these services. Many leisure facilities are provided with the intent to promote active leisure choices (and often subsidised from the general rate to do so). Halls and parks provide opportunities for social connectedness that we have all found a new appreciation for in the covid environment and cycleways and walking facilities do not just have transport outcomes in mind. Each of these provides the opportunity for collaboration between the health sector and local government
- Local authorities also have policy tools available to them that generate health outcomes. These might relate to policies as significant as emission reductions polices (such as urban design, purchasing decisions etc.) or as micro-level as their rate remission policies and policies banning sugary drinks from council leisure and cultural facilities

[2] Section 10, Local Government Act 2002.

- Advocating to central government and other providers for health resources and facilities. The so-called 'Heartland Group' of Local Government New Zealand (rural and provincial councils) has its roots in the Health Action Group formed to combat the withdrawal of rural services in the late 1980s and 1990s
- the provision of some regulatory services e.g. food inspection, inspection of building construction to ensure construction meets healthy building standards. This is the closest the sector comes to meeting direct provision of a health service and
- We are aware of some small-scale funding of others to deliver in the community e.g. some small-scale funding to help retain GP services in rural communities and limited contributions towards the local retention of hospital services.

One of the health system principles speaks of the importance of engagement in the operation of the health system. Similarly, one of the objectives of Health New Zealand is to encourage community participation in health improvement and service delivery.

This goes to first element of the purpose of local government – as an agent through which communities make decisions and act locally. Local government has a key role to play as a convenor and broker, that is, the agent for bringing those who can influence results together. So we have a strong interest and stake in how direct health service delivery addresses the needs of our communities.

In principle we agree that the present health system is fragmented and lacks overall system leadership. We've also noted that increasing government funding for health has not resolved the ongoing financial sustainability issues in some DHBs. And we are on the public record as expressing some doubts as to the degree of local democracy truly afforded DHBs in the present system.

However, it remains critical for local communities to have a say in the design and delivery of services with that in mind. That is one of the guiding principles of our submission and has informed our views on matters such as the degree of engagement with 'health consumers' who are in actual fact communites of interest, as well as in the concept of locality plans and the practice of locality planning .

Government Policy Statement

Equity

The purpose of the Bill is to achieve equity by reducing health disparities among New Zealand's population groups. But there is not much reference to equity as an outcome in the GPS (or any of the strategies for that matter).

We suggest that as a minimum the GPS include a statutory objective noting that working towards achieving equity of outcomes and access to health services are a 'critical' strategic goal/vision for the system. The GPS should demonstrate how equity of outcomes (not just service accessibility) are addressed.

While it could be argued that such an objective would be a Government of the day policy decision there is a convincing argument to say that it is so fundamental to the health system that it should be 'enshrined in legislation' rather than left to different government administrations to adopt as a policy matter.

Duration

Clause 30(3) requires that the strategy cover at least 3 consecutive fiscal years and has a 'shelf life' of three years. That aligns with the electoral cycle. But health is one of the larger expenditure items in the Government budget (behind social welfare and education).

An effective GPS would be strategic, and therefore have a duration that is a bit more than the lower end of medium term. The local government equivalent (the long-term plan) must have a minimum duration of 10 years. We submit that the GPS should at least match this.

Engagement

The GPS appears to sit at the top of an implicit legislative hierarchy of documents e.g. GPS, health strategies, New Zealand Health Plan.[3] It sets the direction for the health system including priorities for investment. It is a document of relevance to all New Zealanders.

We are surprised that the legislation leaves so much of the engagement process open to Ministerial discretion. It appears entirely up to the Minister who they engage with (beyond the two health entities), how they engage and for how long. We submit that the Minister should be required to engage with the public not those individuals and groups as they consider appropriate.

We further add that there should be some minimum level of engagement expected of the Minister. Indeed it seems inconsistent with the health system principles for

[3] Althiugh the legislation is silent on the degree to which the GPS binds the suite of strateges, however the Minister is responsible for preparng the strategies and we would therefore expect the strateges would give effect to the priorities in the GPS.

there not to be some guidance. There are some elements of the Local Government Act that may assist here in requirements that:

- the Minister prepare a proposal as the basis for engagement and
- the Minister allow a minimum period for written feedback on the strategy (one month is the usual period).

This does not preclude additional engagement – for example workshops or meetings, or longer periods. It also does not dictate the form or content of the proposal. But it does meet the key elements of engagement e.g., it is an exchange of information, it involves the preparation of a proposal, and a genuine period for the engaged party to consider its response.

Recommendations: Government Policy Statement on Health

1. **That the Government Policy Statement be amended by adding an explicit require to explain how the statement addresses equity issues**
2. **That clause 30(3) be amended by replacing all references to three years with ten years.**
3. **That clause 31(d) be amended to read "engage with the public'**
4. **That a new clause 31(e) be added to the Bill which requires the Minister to prepare a proposal, allow at least one month for the engagement and invite written feedback on the proposal.**

Health New Zealand

Objectives

Section 13 set out three objectives for Health New Zealand (HNZ). These are what would be expected from a system leader.

We have one minor comment. Subclause (c) refers to collaboration with "other social sector agencies." The term social sector agencies has different meanings in different contexts. For example, it could be interpreted to mean the community and voluntary sector. Within the Wellington beltway it refers to a specific grouping of departments. Both appear unduly exclusive. Both HNZ and the Maori Health Authority to have to work with the community and all agencies involved with the delivery of services that have an influence on health in different communities.

Recommendation: Objectives of Health New Zealand

5. That clause 13(c) be amended to refer to collaboration with 'other agencies' rather than 'other social sector agencies'.

Board Membership

Clauses 12 and 22 set out the requirements for membership of the boards of Health New Zealand and the Māori Health Authority. We concur with the knowledge sets and experience listed in these clauses. But there is one omission that stands out. Neither section explicitly requires the boards of either organisation to have knowledge experience of expertise of the procurement and delivery of health services to meet the needs of different communities.

As drafted clause 12(3) refers only to the "public funding and provision of services", and clause 22(2) refers to this and also to the "cultural safety and responsiveness of services". On a strict reading of the clause, the appointment of anyone with a background in any public service would satisfy this requirement (e.g. a librarian or a policy analyst). We doubt this was the intent.

On another point, the reference to the public funding and provision of services appears to preclude appointment of a person with a knowledge of private health provision. We submit that the Bill should be drawing on a wide pool of candidates and those with this background ought not to be precluded if they can contribute to the Board.

Recommendations: Board skills

6. That clause 12(3)(b) be amended to read "the funding and provision of health services".

7. That clause 22(2)(d) be amended to read "the funding and provision of health services".

Disputes

Clause 28 sets out the process for resolving any disputes between HNZ and the MHA. A dispute that is significant enough to require recourse to a legal mechanism and potential involvement of a Minister is far more likely to be a policy rather than an operational matter (indeed Ministers should have little role in resolving an

operational matter as a rule). That being the case, the Chief Executives may not be the best parties to resolve the dispute, as they are bound to implement the policy decisions of their boards. We suggest that the onus for resolving disputes should first be placed on the Chairs of HNZ and the MHA.

Recommendation: Disputes between HNZ and the MHA

8. That clause 28(1)(b) be amended by replacing the words "chief executives" with the word "chairs".

Strategies

Clauses 37 to 43 all relate to the suite of strategies including the purpose of each, the process for adoption, and obligations to monitor the strategy.

The Placement of Mental Health and Addiction within the Suite

He Ara Oranga, the report of the last inquiry into mental health and addiction reported that each year one in five New Zealanders experience significant mental illness or mental distress, and that over the course of a lifetime between 50 and 80 percent experience mental health challenges or addiction. Mental health is the health issue that most touches upon local authorities and the services they provide for the community.

We are not certain where mental health sits within the set of strategies. Of course we are aware that the Government released *Kia Manawanui,* the 10-year mental health and wellbeing strategy, in September 2021. However this strategy is a voluntary one, and this legislation is intended to be a fundamental reset of the health system

Coverage

As with the GPS, the strategies should be taking at least a medium-term view (and preferably a long-term view). Yet the only strategy that has a specified coverage is the New Zealand Health strategy, and in requiring that this strategy cover a period of 5-10 years it enables a minister to take a medium-term focus. As with the GPS, each strategy should cover at least ten consecutive fiscal years.

Engagement

These strategies are intended to guide the New Zealand Health Plan, and therefore have a significant role in the system. The engagement requirements are not well

defined. They appear to apply to Health New Zealand, the Māori Health Authority and other health groups the Minister considers affected by the strategy,
We repeat our earlier comments about the GPS, the community as a whole could well have views on these documents

Monitoring and review

Clause 43 requires the Minister to regularly monitor and review the heath strategies and assess how the health system has performed against the strategies. We note there is no obligation on the Minister to report the results of the monitoring and assessment. The results of the monitoring and review will be of significant public interest, especially to the health entities and other health groups (the results may inform their own consideration of future strategies). The results should be made publicly available.

Recommendations: Health Strategies

9. That the Committee take advice on the intended place of mental health and addiction in the suite of strategies.

10. That clauses 37 to 40 be amended to require each strategy to cover a period of at least 10 fiscal years.

11. That clause 41 be amended to require the Minister to engage the public as per the GPS.

12. That clause 42 be amended to require the results of monitoring and review be made publicly available.

Locality Plans

Taituarā supports the proposed locality plans as a tool for allowing local communities a say in the design and delivery of services at local level. Local government has strong interest in and expertise to offer in preparing and engaging on strategies and plans. Our 'spatial view' is across the four well beings.

Our spatial view will be further strengthened by obligations coming as part of Resource Management Act reforms. Local authorities will be obliged to work with the crown and other parties to develop a regional spatial strategy- a means of synthesising community planning, land use planning and infrastructure planning into

a single coherent story about plans to progress the wellbeing of the community. It is hard to argue that health is not a contributor the wellbeing of the community e.g. by having services in the right locations.

HNZ and the MHA need to be working with local authorities on the development of locality plans. We note the engagement requirements with these plans are a great deal stronger than the GPS, strategies, and the Health Plan. The one exception is that there is no reference to local communities in the purpose of Health NZ (clause 14).

The effectiveness of locality plans will be critically dependent on how localities are defined under clause 48. There may be some temptation to use the present DHB boundaries as the locality boundaries, especially when viewed in conjunction with the regional arrangements for delivery permitted under clause 97.

We submit that those boundaries were determined more than 20 years ago, and that there have been changes in technology and society that necessitate review and change. The Bill envisages that HNZ will have a reasonable time to determine the boundaries of localities. We submit that part of the process for determining localities should involve HNZ setting out its criteria for determining localities and seeking public comment upon those criteria. That could be done within six months of the establishment of HNZ. Local government can make a positive and meaningful contribution towards developing locality plan areas and their preparation.

There is also no direct requirement on HNZ to engage with anyone other than the MHA when determining the number of localities and their boundaries. This is a critical step in building the confidence of local communities in the reforms following the "loss of their DHB." Earlier in this submission we made recommendations regarding engagement processes for the GPS and health strategies. Those should serve as a basis for engagement on the first determination of localities.

<u>Recommendations: Localities and Locality Plans</u>

13. **That clause 14(g) be amended to read "to develop and implement locality plans jointly with local communities"**

14. **That clause 48 be amended by adding a requirement that Health New Zealand prepare and engage on a set of criteria for determining localities within six months of establishment.**

15. **That clause 48 be amended to add a requirement to "engage with the public.**

16. That a new clause 31(e) be added to the Bill which requires HNZ to prepare a proposal, allow at least one month for the engagement and invite written feedback on the proposal.

Observers

The legislation makes provision for the Minister to appoint an observer if concerned about the performance of HNZ or the MHA. The power itself is appropriate – it is a device for detecting and resolving performance issues early. We see similar powers in other legislation (including the Local Government Act).

However the role the legislation confers on the observer has been predicated on the assumption that the performance issue is something that having an observer attend a meeting may assist to resolve. That may not be true of many such problems – for example, continued turnover of senior staff is often an internal culture issue that requires an ongoing commitment. The observer's role appears to be to attend a meeting, get information, explain the Government's policies and report back to the Minister.

The only step contemplated after that is the dismissal of a board or member. The Bill sets out no intermediate options. For example, a performance issue is self-contained and might need someone with powers to act to resolve (for example a term used in other legislation is the Crown Manager). We submit that the Ministerial powers of intervention need further development including some consideration of the range of circumstances that might arise, and how well suited an observation power is to each. The observer might, for example, assist with the development of an improvement plan as per clause 57.

Recommendations: Observers

17. That clause 55 be amended to add a requirement for the Minister to provide the Board with notice of the appointment of an observer.

18. That clause 55 be amended to add a requirement for the Observer to engage with the Board before reporting to the Minister.

19. That the Committee consider whether clause 55 or 57 should be supplemented with an advisory role.

Taituarā

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