ANZCA
FPM

Te Whare Tohu o
Te Hau Whakaora

18 August 2025

Clerk
Health Committee Secretariat
Parliament Buildings
Wellington
By email: Health@parliament.govt.nz

Tēnā koutou kātoa

Healthy Futures (Pae Ora) Amendments Bill (the bill)

About the Australian and New Zealand College of Anaesthetists (ANZCA)

ANZCA, which includes the Faculty of Pain Medicine (FPM) and Chapter of Perioperative Medicine, is the leading authority on anaesthesia, pain medicine and perioperative medicine. It is the professional organisation responsible for postgraduate training programs of anaesthetists and specialist pain medicine physicians, and for setting the standards of clinical practice throughout Australia and Aotearoa New Zealand. Our collective membership comprises 9649 fellows and trainees in anaesthesia and pain medicine, of which about 1300 work in Aotearoa New Zealand. ANZCA is committed to upholding Te Tiriti o Waitangi in the provision of competent, culturally safe care, and to promoting best practice and ongoing continuous improvement in a high-quality health system.

This submission is informed by feedback and discussion with New Zealand fellows, trainees, and Committee members, including the New Zealand National Committee (NZNC) and FPM NZ, the Maori Anaesthetist Network Aotearoa (MANA), the Council of Medical Colleges (CMC), and our Australian colleagues.

Introduction

1. This bill reverses the transformative evidence-based direction towards equity and empowerment that the Pae Ora (Healthy Futures) Act, 2022 enabled.

2. ANZCA notes that the bill was developed without consultation or structured discussion with the health workforce, patients / consumers, public health academics or community health advocates and with only “negligible discussion with Health New Zealand” (Regulatory Impact Statement, p2).

3. Although it contains important provisions to improve financial accountability, ensure transparency, and address barriers to an efficiently operating health system, it is underpinned by a fundamental misapprehension of the principles and drivers of population health.

4. Consequently, rather than improving the timeliness, quality and sustainability of health services, the bill’s proposed changes will lead to further disruption, uncertainty, and potential disintegration of key components of an already fragile health system. ANZCA **does not support** the bill.

5. The bill follows the direction of the Treaty Principles Bill, the Regulatory Standards Bill, and Medicines Amendment Bill in proposing the deletion of widely accepted principles, standards, values, and language, and the strengthening of ministerial control, that have attracted

widespread opposition, including from ANZCA. ANZCA opposes the removal of health principles and the New Zealand Health charter which were developed in concert with the health sector and consumers, and which underpin the trusted relationships between clinicians, patients and whānau.

6. ANZCA rejects the bill's further marginalisation of Māori health services following the disestablishment of Te Aka Whai Ora, the Māori Health Authority, which effectively transitions Māori health services from a highly regarded partnership model to a separatist, apartheid one.

7. Clause 11 (Political neutrality) requires workforce compliance with principles that are not only not yet publicly available and open to change, but that provide a means to undermine the primacy of doctors' duty to patients by policy. This may also undermine the culture changes Dr Levy is trying to achieve in clinical leadership in Aotearoa New Zealand[1].

8. Moreover, in the context of the Employment Relations Amendment Bill and the Public Services Amendment Bill, clause 11 poses a heightened ability for medical practitioners to be restrained from expressing independent, expert opinion.

9. ANZCA notes with concern the further shift of responsibility, control, and accountability for health inherent in the bill, away from the Ministry of Health, the government agency headed by the Director General, and towards Health New Zealand and its ministerially appointed board. The shift reduces the comprehensive oversight, continuity and coordination needed to improve population health over time and increases the focus on immediate health service demand that is more susceptible to public and political pressure. The balance between short term targets and long-term goals, such as reducing health inequity, needs to be maintained, not further politicised.

10. ANZCA does not support mandating specific health targets in legislation.

11. Removing the requirement for the New Zealand Health Plan to be audited compounds these concerns, especially given the Auditor General's unequivocal (and unacknowledged) finding that the plan 2024-2027 "did not meet expectations of a costed plan".

12. There is no merit whatsoever in allowing the publicly funded membership of highly expert committees, responsible for ensuring public health and safety over a complex range of issues, to be subject only to a minister's 'satisfaction'. Scientific, cultural, and clinical expertise and experience need to be specified to maintain the integrity of the health system.

13. ANZCA does not oppose interaction with private providers of health services; many of our members work in both private and public services. We take this opportunity to explain what is needed to ensure that such interaction leverages, sustains and develops the skills and infrastructure we have, and avoids adverse outcomes in the long term.

14. In principle ANZCA **supports** the inclusion of infrastructure and more rigorous attention to long term planning and measurement, though these are poorly defined. We suggest inclusion of quality measures such as Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs).

15. Our concern is that the bill does nothing to address the continued lack of robust, sustainable workforce planning, and embeds prioritisation of high-cost interventions such as surgery, with no oversight of outcomes aside from wait times.

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[1] Levy, L. Reforming Health New Zealand: confronting crisis, sustaining recovery. NZMJ [Internet]. 2025 0815; 138(1620): P9-12. Available from: 1620-editorial.pdf

16. The bill leaves uncertainties, including, critically, whether the six Pae Ora Strategies which encompass the New Zealand, Hauora Māori, Rural health, Women's health and Health of Disabled People strategies, are to remain.

17. Further discussion on selected points follows. Where possible, we have recommended changes to the bill, but our overall recommendation is that the bill **does not** proceed.

18. ANZCA supports the Council of Medical Colleges submission and wishes to make an oral submission.

Discussion

Clauses 4-10 Title, Te Tiriti o Waitangi, and health principles, and Clause 19 Purpose, and Function, of iwi-Maori Partnership boards

19. Changing the order of languages is both inconsequential and important. It does not directly affect health but signals a determination to assert the precedence of English which is unnecessary and unhelpful. Reaffirming the primacy of English implies a deliberate return to the dominance of Western culture and institutional bias that has delivered, in every measure of health, poorer outcomes for Māori, and Pacific peoples, despite the apparent "equality" of our health services. Is this what the committee wishes to assert?

20. After decades of successive and contentious structural changes to the health system, as governments grappled with the effect of global changes in technologies, medical science, workforce supply and health demand, the Pae Ora (Healthy Futures) 2022 was widely supported by the health sector and the public (as the summary of submissions on the Pae Ora bill showed). It set a new direction in recognising the social determinants of health, the importance of equity, and the intersection between primary health care, prevention, cultural safety, health literacy, and acute and chronic care delivery.

21. Fundamentally, it accorded Māori the rights recognised in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and Te Tiriti o Waitangi to design, lead, and deliver health services for Māori grounded in Māori values and tikanga, and was backed by appropriate funding, including for commissioning services, supporting governance and reporting requirements.

22. Abundant international and national evidence supports this approach to addressing persistent and unintended health inequity, including the notable outcomes for breast cancer screening, where giving agency to Māori led to significantly increased rates of screening of breast cancer, not only for Māori wāhine, but for *all* women[2].

23. Culturally competent and safe practice – ensuring people get the right messages enabling them to make healthy decisions, and that they have equitable access to information, services,

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[2] Shea, S., Cragg, M., Ioane, J., Atkinson, M., & McGregor, S. (2021). Me aro ki te hā o Hineahuone – A national evaluation of breast and cervical screening support services. Shea Pita & Associates Ltd. https://www.health.govt.nz/system/files/2021-11/breast-and-cervical-screening-support-services-evaluaton-report-for-ministry-health-15-nov2021.pdf

Te Rōpū Rangahau Hauora a Eru Pōmare. (n.d.). BreastScreen Aotearoa Māori Monitoring. University of Otago, Wellington. Retrieved August 11, 2025, from https://www.otago.ac.nz/wellington/research/groups/research-groups-in-the-department-of-public-health/erupomare/research/breastscreen-aotearoa-maori-monitoring

and treatments – is cost effective. Regressing to an outdated model of (mono) cultural dominance, ignoring the current and future needs of our diverse society, and obligations under te Tiriti o Waitangi, will exacerbate rather than reduce entrenched disparities in health and the cost of preventable disease and disability, pain, and suffering.

24. The bill, which follows the disestablishment of the Te Aka Whai Ora Maori Health Authority, (and incidentally the reorganisation of Te Arawhiti and Te Puni Kōkiri roles) sidelines Māori. It reframes the Hauora Māori Advisory Board (HMAB) and IMPB's "from strategic partners with signing authority into community engagement advisors, removing their power to shape and approve health service delivery. This marks a serious recalibration of Māori influence within the health sector, which undermines both the spirit of the Pae Ora reforms and commitments under Te Tiriti o Waitangi."[3]

25. ANZCA strongly opposes Clause 19 replacing sections 29 and 30 relating to the **Purpose, and Function, of iwi-Maori Partnership boards**, which effectively reduces their status to being of one stakeholder among many, rather than sovereign partners with the legal power to sign off on local health plans. Instead of sitting alongside hospitals, NGOs, and health providers, as partners in planning, designing and delivering health services to meet the needs of all New Zealanders, the IMPBs are essentially powerless to do more than 'submit' and hope that, amidst the plethora of other targets and the weight of the 'mainstream' local district and regional structures, their expert advice will be acted on, not just 'considered'.

26. Since the bodies they are submitting to no longer require any knowledge of Te Ao Māori and the factors affecting Māori health, that is less likely. The bill provides for separate Māori health structures, without the power to plan and provide effective services.

27. The ongoing costs of preventable poor health in our largest, fastest growing young population - Māori - are unsustainable. We need Māori, and indeed all New Zealanders, to reach their health potential. This bill reverses the transformative, evidence-based direction towards equity and empowerment that the Pae Ora (Healthy Futures) Act enabled.

28. The removal of health sector principles and the Minister's obligation to consider the Health Charter further underlines the fundamental misapprehension of modern health policy and service delivery. These were developed in concert with the health sector, including those responsible for delivering health services, for training and educating the health workforce, and for researching and analysing evidence supporting health interventions. To reject them is to reject the science that underpins the expertise of the health workforce and the safety and effectiveness of health service.

29. Several factors contribute to persistent shortages of highly educated and skilled clinicians, but perhaps the most significant contributor to New Zealand's extremely high turnover of doctors and specialists, is concern around the safety and effectiveness of the healthcare they are able to deliver. When basic understanding of the core principles of good healthcare, such as cultural competence and safety is lacking, and/or trivialised as with the Ministry of Health's consultation document Putting Patients First: Modernising health workforce regulation (see ANZCA's submission[4]), health workers will continue to vote with their feet.

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[3] Wataki, M. Major changes on the way for Iwi Māori Partnership Boards. Waatea News. 2025 06 22. Available from: Major changes on the way for Iwi Māori Partnership Boards – Waatea News: Māori Radio Station

[4] ANZCA, Putting Patients First: Modernising health workforce regulation. ANZCA submission to the New Zealand Health committee.2025 04 30. Retrievable from 2025-04-Putting-Patients-First,-HPCA-Review,-ANZCA-letter.pdf

30. ANZCA urges the Committee to reject these changes, affirm Te Tiriti o Waitangi, the health sector principles and the Health Charter that provide the basis for transformative, cost-effective healthcare to meet the current and future health needs of new Zealanders.

Clause 11 (Political neutrality)

31. ANZCA questions the relevance of this clause in health rather than public service legislation which, incidentally, is also currently being amended.

32. Regardless, we strongly oppose the clause for two reasons. Firstly, it requires compliance with policy which is not yet publicly available and subject to change. The principles and standards of the Public Service Act 2020 apply to doctors employed by Health New Zealand (Part 1, subparts 2 and 4) and require them to uphold the public services principles and comply with minimum standards of integrity and conduct relating to those public service principles.

33. At present there is guidance on Standards of integrity and conduct but, according to the website: "A refreshed code reflecting the **principles, values and language** used in the Public Service Act 2020 is in development. The current code continues to apply until a new code is issued." (ANZCA emphasis)

34. It is unlikely that ANZCA would support changes to the "principles, values and language" guiding public service standards, given recent proposed legislation and the noticeable trend (for instance with the upcoming Public Service Amendment Bill) to downgrade recognition of the binding nature of ethical and professional standards, and to reframe the duties of public service as primarily to serve the interests of the government, rather than the interests of New Zealanders.

35. The bill conflates political neutrality with compliance with policy, potentially allowing expert opinions to be dismissed as being politically biased rather than respected as scientifically based.

36. This erodes the 500 year old principle of the primacy of the duty to the patients as expressed in the Medical Council of New Zealand's publication Good Medical Practice (2021) "A doctor's **first** concern is to take care of their patient, and to do so with respect, honesty and professionalism".

37. Medical practitioners, and indeed all regulated health practitioners, are bound by stringent ethical and professional standards under the Health Practitioners Competence Assurance Act, 2003. There is no need for this clause, when professional conduct duties are already and properly established by law, including disciplinary proceedings.

38. If, against the concerted voice of medical practitioners, the bill does proceed, ANZCA recommends amending Clause 11 **New section 11A(b)(ii)** by inserting "*subject to ethical duties held by members of a registered profession"* before *"Health New Zealand, and the groups and individuals in it, to comply with minimum standards of integrity and conduct relating to those public service principles."*

Clause 14 (2) Private health care providers

39. The addition of "*including, to avoid doubt, private health care providers*" in section 14(1)(k) that lists agencies, organisations and individuals that Health New Zealand should collaborate with as part of its functions is unnecessary, as evidenced by the collaboration that already occurs.

40. Many ANZCA members work in both private and public services, and we warmly support using all resources available. An important consideration is maintaining training pipelines, which ensure trainees are exposed to the full range of acuity at the appropriate stage of training.

Outsourcing routine elective surgery to private hospitals could limit training opportunities (currently provided in public hospitals) and extend training times. There are exceptions, however, and we are confident that robust contracting models - such as those based on the Royal Australasian College of Surgeons Position Statement: Principles for Outsourcing Planned Care Surgery - could be developed and implemented.

41. This would require substantial investment in establishing secure, interoperable information systems to capture national health data to inform continual improvement of patient, workforce, and service outcomes.

Clause 21- 23 Targets

42. While there is nothing extraneous in the proposed new targets, we question whether legislation is the right vehicle for specific health targets, as it limits flexibility and potentially the ability to respond to new areas of concern, such as pandemics. Mandates to address a plethora of targets are not likely to deliver the coordination and integrated approach a responsive, cost-effective health system requires.

43. Moreover, many of the GPS targets are focused on hospital level services. Investment into primary care and preventative health (the fence at the top of the cliff). has far greater return on investment in improving health and productivity than into the ambulance at the bottom of the cliff.

44. The bill aims to ensure “quality and timely access", but targets often ensure that, in practise, all that is measured is time.

45. As one of our Faculty of Pain Medicine fellows explains:

> “*The key issue is what is measured. Currently, for non-cancer care, hospitals only measure how wait times. They do not, for example, ask people to score pain or quality of life. Someone who waits only 6 weeks for a knee replacement is seen as a success, but because no one asked the person to indicate how bad their pain or disability was before and then after; the fact that they are now in worse pain, worse quality of life and can no longer walk is not captured.”*
>
> Dr Joseph, FFPM ANZCA, Specialist Pain Medicine Physician

46. This is particularly important when thinking about the management of the greatest cause of 'years lived with disability'. Currently high-cost interventions (e.g. surgery) are being prioritised with no oversight of outcomes aside from wait times.

47. The introduction of systematic collection of Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) as standard for all interventions (including/especially surgery) would allow robust monitoring of quality and also consideration of the cost effectiveness of interventions.

48. Such transformative change, supported by appropriate data systems is what is needed to drive systemic improvements and better health outcomes.

49. ANZCA recommends appropriate outcomes measurements of timeliness and quality of health interventions, such as PROMs and PREMs. Should the bill proceed we suggest inserting a requirement in relevant sections (for example by inserting “*and appropriately measure*” after *access in* Clause 5 amending Section 3 (**Purpose of this Act)** subclause (2) (d): *ensure that patients get timely access to quality health services).*

50. Chronic pain, one of the costliest conditions nationally and the greatest cause of "years lived with disability' which affects one in five New Zealanders - is absent from both health targets and nationally coordinated health services.

51. ANZCA recommends the inclusion of chronic pain services in national planning consistent with the *Mamaenga roa Model of Care for people living with chronic pain* developed by the Office of the Chief Clinical Officers in 2022.

Clause 32 Appointment of expert advisory committee members

52. As per ANZCA's submission on the Medicines Amendment Bill[5], removing parameters that ensure appropriate knowledge and expertise on expert committees, will undermine public safety, which is assured by a web of regulation. The single criterion for appointment - that the Minister is satisfied that the person is "suitably qualified" - is unacceptably vague for a position requiring specific expertise in public health.

53. The current preventable outbreak of measles in the US[6] provides a graphic example of how quickly scientifically-based public health services that have substantially improved population health and reduced the suffering and costs of disease can be lost when informed expertise is replaced by confident, unsubstantiated opinion. Even more telling is the huge loss of life from Covid-19 pandemic the US suffered (434 per 100,000 compared with 19 in New Zealand[7]) because of the failure to heed the advice of its epidemiological experts.

54. Repealing Section 93(4) detailing requirements for cultural, clinical, and scientific expertise – that the Minister must be "*satisfied that the committee collectively has knowledge of and experience and expertise in relation to population health, health equity, te Tiriti o Waitangi (the Treaty of Waitangi), epidemiology. Health intelligence, health surveillance, health promotion, health protection and preventative health*." – is short sighted and dangerous.

55. It is further evidence of the fundamental misunderstanding of what constitutes and drives cost-effective, evidence-based public and population health.

Clauses 26 and 27 Removing Auditor-General's oversight of the New Zealand Health Plan

56. ANZCA opposes repealing section 52(2)(c) and section 53(2) which removes the requirement for the **New Zealand Health Plan** to be audited by the Auditor General. The rationale given is that this part of the process is time-consuming and delays publication of the New Zealand Health Plan. The Auditor-General's response to the Commissioner and Deputy commissioner of Health with regard to auditing the New Zealand Health Plan Te Pae Waenga, 30 June, 2024 to 31 July, 2027, (pages 74-85) suggests, however, that reason for the 18 month delay was that that the plan was quite inadequate.

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[5] ANZCA. Medicines Amendment Bill. Submission to the New Zealand Health Committee.2025 04 19. Available from: 2025-04-Medicines-Amendment-Bill,-ANZCA.pdf

[6] https://www.rnz.co.nz/news/world/569654/measles-outbreak-in-us-prompts-questions-over-robert-f-kennedy-junior-s-mixed-messages-on-vaccination

[7] Edouard Mathieu, Hannah Ritchie, Lucas Rodés-Guirao, Cameron Appel, Daniel Gavrilov, Charlie Giattino, Joe Hasell, Bobbie Macdonald, Saloni Dattani, Diana Beltekian, Esteban Ortiz-Ospina, and Max Roser (2020) - "COVID-19 Pandemic" Published online at OurWorldinData.org. available at https://ourworldindata.org/coronavirus'

> … *"I expected the Plan to provide a clear explanation of how the actions have been selected and prioritised, and how the actions will contribute to the achievement of the desired improvements and targets. The Plan does not do this.*
>
> *I consider that a costed plan should clearly set out the publicly funded health services and activities to be delivered and their forecast cost. I expected the Plan to be based on clear and reasonable assumptions about health needs and the expected quantity of service demand, the resources needed to provide those services, and the forecast cost of those resources. The Plan does not do this."*
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> … *"The Plan developed by Health New Zealand does not meet my expectations for a costed Plan as set out above."*
>
> *…" I was not able to obtain sufficient appropriate audit evidence to provide a basis for an opinion on the Plan."*
>
> John Ryan Controller and Auditor-General Wellington, New Zealand 23 May 2025

57. The correct response should surely be to improve auditable data, not remove the sound oversight of the Auditor General.

Conclusion

58. ANZCA **does not support** the bill which makes both inconsequential and substantial changes to Health that, on balance, will not deliver quality, cost-effective sustainable healthcare, or improve the health of New Zealanders. The bill does not enjoy the confidence of the medical workforce or the cross-sector support of the Act it seeks to amend.

59. Although there may be merit in additional objectives relating to the timeliness of health services and infrastructure planning, the lack of detail and deletion of the health principles including Te Tiriti of Waitangi, among other changes, renders them meaningless in the real world of delivering timely, quality health care.

60. We **recommend** that you note that ANZCA **strongly opposes**:

- Clause 4 and clause 5 (1) amending the **Title** and the **Purpose** of the Act to put the English language *Healthy Futures* before te Reo Māori *Pae Ora*.
- Clauses 6 and 7 amending section 4 (**Interpretation**) and section 5 (**Guide to this Act**) respectively, repealing the definitions of health sector principles and New Zealand health charter.
- Clause 8 amending section 6 Te Tiriti o Waitangi (the Treaty of Waitangi), which despite subclauses (4) and (5) regarding iwi-Māori partnership boards (IMPB), isolates Māori health and Māori health service provision from the rest of the health service by:
  - removing the provision for Māori to have "*a meaningful role in the planning and design of local services*" without making the same provisions available for local services that other districts have
  - removing requirements for the board of Health New Zealand to have any "*knowledge, skill, expertise in relation to Māori*" or to "*maintain systems and processes to ensure understanding of Te Tiriti o Waitangi, kaupapa Māori services, cultural safety and responsiveness of services, mātauranga Māori and Māori perspectives of services.*"

- removing requirements for Health New Zealand to" *…report back to Māori on the performance of its functions*" without making provision for funding, reporting back, or assessing performance of IMPB functions elsewhere.

- Clause 9 repealing section 7 (**Health sector principles**) and all clauses repealing the principles, including clause 25(3) amending section 51.
- Clause 10 repealing section 10(1)(d) of section 10 (**Overview of Minister's role)** removing "*endorsing the New Zealand Health Charter*" from the Ministers role and all clauses removing the Health Charter, including clause 28 repealing sections 56 to 58.
- Clause 11 inserting new section 11 A (Obligations as Crown agent including in relation to political neutrality)
- Clause 12 amending section 12 (**Board of Health New Zealand**) by removing the requirement for the board collectively to have knowledge, experience and expertise in relation to *te Tiriti o Waitangi and Tikanga Māori, public funding and provision of services, public sector governance and government processes, financial management* and proposing that the Minister appoint "*only people who, in the Ministers' opinion, have appropriate knowledge skills and experience to assist the board to perform its role*".
- Clause 12 amending section 12 (**Board of Health New Zealand**).
- Clause 14 (2) amending section 14 (**Functions of Health New Zealand**) It is unnecessary to insert "*including, to avoid doubt, private healthcare providers*" since collaboration with private providers already occurs, though it remains unclear how broad that collaboration is expected to be and whether it will include consideration of ACC-funded and privately funded healthcare as well public health services.
- Clause 15 amending section 15 removing the requirement for Health New Zealand to engage with IMPBs. It is difficult to see how it could continue to properly support IMPBs without engagement. Advice provided by the Hauora Māori Advisory Board, to whom the 15 IMPBs report, is not comparable to the input and control formerly afforded IMPBs who could determine priorities for kaupapa Māori services.
- Clause 16 amending section 16 (**Additional collective duties of board of Health New Zealand**) by repealing s15(1)(d)(ii) ensuring that Health New Zealand "*maintains systems and processes that ensure Health New Zealand has the capacity and capability to understand te Tiriti o Waitangi (the Treaty of Waitangi), kaupapa Māori services, cultural safety and responsiveness of services, matauranga Māori, and Māori perspectives of services*."
- Clause 17 repealing section 16A (**Engaging with and reporting to Māori**).
- Clause 18 new section 20 *Infrastructure Committee* subsections (4-6) relating to the Minister's sole responsibility for appointment of the members of the committee, and inadequate provision for ensuring the requisite Māori, technical and clinical expertise necessary for informed decisions on systems supporting the health of New Zealanders.
- Clause 19 replacement of sections 29 and 30 relating to the **Purpose, and Function, of iwi-Maori Partnership boards**, which effectively reduce the status of the IMPBs boards to "being of one stakeholder among many, rather than sovereign partners with the legal power to sign off on local health plans. They would no longer hold veto rights, instead sitting alongside hospitals, NGOs, and health providers.

- Clause 23 inserting New Section 36A (**Targets that must be included in the Government Policy Statement (GPS)**) namely cancer management care; immunisation of children; admission to, and discharge and transfer of patients from emergency departments; specialist assessments; elective treatment; and access to primary care. Targets mean that planning and funding will be focused on this selective list, potentially excluding or underfunding other health needs, and reducing the ability to address unanticipated health risks. A systematic approach is needed.

- Clause 26 repealing section 52(2)(c) and clause 27 repealing section 53(2) removing the requirements for the **New Zealand Health Plan** to be audited by the Auditor-General.

- Clause 29 inserting new section 65A (**Minister may direct Health New Zealand regarding Public Service Commissioner**) which is superfluous.

- Clause 31 amending **Section 89** (**Hauora Advisory Committee**) specifically subclause (2) which defines the purpose of the Committee as providing advice only to the Minister of Health and the board of Health New Zealand for whom requirements for understanding knowledge and expertise of kaupapa Māori has been expressly removed by this bill. Consultation with the Minister of Māori Development reinforces the 'top down' approach of ministerial control, rather than shared autonomy.

- Clause 32 amending section 93 (**Expert advisory committee on public health**) repealing s93(4) which requires the Minister to be "*satisfied that the committee collectively has knowledge of and experience and expertise in relation to population health, health equity, te Tiriti o Waitangi (the Treaty of Waitangi), epidemiology. Health intelligence, health surveillance, health promotion, health protection and preventative health*." It is essential that the committee has the requisite expertise to advise on matters critical to public health and safety.

59. If the bill proceeds, ANZCA recommends the following amendments:

- Clause 5 amending Section 3 (**Purpose of this Act)** subclause (2) (d) *ensure that patients get timely access to quality health services,* by inserting "*and appropriately measure*" after *ensure* to clarify the requirement for appropriate measurements of timeliness and quality, PROMs and PREMs.

- Clause 11 **New section 11 A inserted (Obligations as Crown Agent, including in relation to political neutrality** amend 11A(b)(ii) to read "*subject to ethical duties held by members of a registered profession, Health New Zealand, and the groups and individuals in it, to comply with minimum standards of integrity and conduct relating to those public service principles."*

- Clause 13 amending **section 13 (3)** (**Objectives of Health New Zealand**) by inserting "all" into the proposed new subsection (f) to provide and plan for quality, cost-effective, and financially sustainably infrastructure to deliver services to *all* New Zealanders.

- Clause 14 amending **section 14 (Functions of Health New Zealand**) Objectives of Health New Zealand – insert "all" to deliver services to all New Zealanders.

- Clause 23 inserting **new section 36A (Targets that must be included in the Government Policy Statement on Health**) adding Chronic pain services consistent with the *Mamaenga roa Model of Care* to the targets.

- Clause 18 (**Board of Health New Zealand must have infrastructure committee**) **new section 20 (2)** inserting "including health workforce and information and communications

technologies (ICT)" the word infrastructure to clarify that both are intrinsic infrastructure for the delivery of safe, quality health services.

60. ANZCA would like to make an oral submission.

Nāku noa, nā

Rachel Dempsey
Chair, New Zealand National Committee

Brendan Little
Deputy Chair, New Zealand National Committee

Australian and New Zealand
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