

## McGuinness Institute Oral Submission Notes

### Healthy Futures (Pae Ora) Amendment Bill Health Committee 3 September 2025

## 1.0 Introduction

We would like to thank the Health Committee for inviting feedback on the Bill.

**We recommend that the Bill is not passed as it currently stands. We make twelve key recommendations below.**

### 1.1 Institute's Background

The Institute was founded in 2004 as a non-partisan think tank working towards a sustainable future for Aotearoa New Zealand.

The Institute has undertaken extensive work on pandemics, including COVID-19, under the research project [PandemicNZ](#). Our signature book is *COVID-19 Nation Dates: A New Zealand timeline of significant events during the COVID-19 pandemic*. Our work on pandemics began in 2005, and a complete list of our publications on the subject can be found on our website.

### 1.2 Why this Bill is important

The Estimates of Appropriations 2025/26 notes: 'Vote Health ('the Vote'), \$31,052 million in 2025/26, is a significant public investment in the wellbeing of New Zealanders and their families.'<sup>1</sup>

## 2.0 Key topics and recommendations

The McGuinness Institute's key concerns include the below:

- the Bill fails to distinguish between strategy and plans, creating unnecessary confusion.
- the Bill fails to ensure the Minister (and the country) gain health intelligence through the failure to collect timely information on the status of the system, and
- health legislation has not been updated in response to the lessons learned from the COVID-19 pandemic.

We also have wider concerns over the general direction of amendments proposed under this Bill. Given the Ministry of Health – Manatū Hauora (MOH) and Health New Zealand – Te Whatu Ora (HNZ) are both involved in New Zealand's health system, one would expect more alignment between the two organisations and more clarity over the two different roles that are being proposed. If MOH is the 'planner' and HNZ is the 'doer', those distinctions should be clearly defined in legislation. Instead, the legislation and roles appear unclear. It is also extremely difficult to understand how existing strategies and plans will work together and, in particular, which strategies and plans link to each other, and how one strategy might operate at a different hierarchy than another. The terms should be carefully used to provide a systematic and easy-to-understand hierarchy of key documents.

Finally, we note there is no discussion of AI and how technology will integrate with the health sector. We wonder how AI and the pace of its development might impact, and ideally be used to improve, New Zealand's health system. In this regard, the Institute considers a great deal more research and stakeholder engagement is necessary before this Bill should be passed.

## 2.1 Summary of Institute's recommendations

Our 13 recommendations include:

- **Recommendation 1: Clauses 34-40 Government Policy Statement on Health should be renamed to add priorities to the title, so it reads 'Government Policy Statement on Health Priorities'.**
- **Recommendation 2: Clause 50 New Zealand Health Plan, should be renamed 'Health New Zealand Strategy'.**
- **Recommendation 3: Clause 55 Locality Plans, should be renamed 'Health New Zealand Local Strategies'.**
- **Recommendation 4: Clause 41 New Zealand Health Strategy and Clauses 50–53 New Zealand Health Plan should be merged into one document – 'Health New Zealand Strategy' – as the distinction between the two is unclear.**
- **Recommendation 5: Expand Schedule 1, Clause 51.**
- **Recommendation 6: Embed pandemic preparedness and crisis management, publish monthly stocktakes of our National Reserve Supply (NRS), and establish a separate Epidemic/Pandemic Cabinet Committee to regularly review our preparedness.**
- **Recommendation 7: Remove Clause 11A as it is repetitive and unconstructive.**
- **Recommendation 8: Keep equity as a guiding principle.**
- **Recommendation 9: Support the public healthcare system rather than outsourcing care to the private sector.**
- **Recommendation 10: Undertake and share international analysis so our Bill can be consistent with international standards, and so that we can learn from our international partners.**
- **Recommendation 11: Design legislation which incorporates futures-thinking, including AI.**
- **Recommendation 12: Design legislation which includes how to deal with antibiotic resistance.**
- **Recommendation 13: Require the creation of a Monthly Healthcare Dashboard that sets out the status of the healthcare system.**

## 2.1 Distinguish between strategy and plans

The way it is portrayed in existing legislation and supporting documents is that the Health Act 1956 (the key organisation being MOH) deals with strategic direction and the Pae Ora (Healthy Futures) Act 2022 (the key organisation being HNZ) deals with implementing that strategic direction. One would expect this distinction to be clear in policy, however in our view, it is not.

Below we outline the difference between the two types of documents:

**Strategy:** A strategy should set out the strategic direction, and the best way to test it is whether another direction has been considered but not progressed. The strategy is about finding the best approach. A strategy document should be relatively short, although it often takes a long time to develop, as it requires a lot of resource and energy to select the most appropriate strategic approach.

**Plan:** A plan is operational and therefore should set out specific details including the dates, times and resources required for implementing the strategy. A planning document is long and detailed. Appendix 5 of this submission includes the McGuinness Institute's strategy pyramid. It aims to show the distinction between purpose, strategy and execution and, for the purposes of this discussion, where strategy stops and execution (as in planning) begins.

The current legislation muddies the waters between a strategy and a plan, and unfortunately, the amendment amplifies this messiness. There needs to be a clear hierarchy of strategies and plans in place, and clear roles and responsibilities assigned to the entities involved.

If the Pae Ora (Healthy Futures) Act 2022 is to become the home for strategy and operational plans, those distinctions need to be clear and consistent.

We therefore propose:

**Recommendation 1: Clauses 34-40 Government Policy Statement on Health should be renamed to add priorities to the title, so it reads 'Government Policy Statement on Health Priorities'.**

**Recommendation 2: Clause 50 New Zealand Health Plan, should be renamed 'Health New Zealand Strategy'.**

This is because it only relates to goods and services provided by HNZ (see Clause 50 (2): "The purpose of the plan is to provide a 3-year costed plan for the delivery of publicly funded services by Health New Zealand").

**Recommendation 3: Clause 55 Locality Plans, should be renamed 'Health New Zealand Local Strategies'.**

**Recommendation 4: Clause 41 New Zealand Health Strategy and Clauses 50–53 New Zealand Health Plan should be merged into one document – 'Health New Zealand Strategy' – as the distinction between the two is unclear.**

If a separate plan is needed to distinguish between the whole health system and the HNZ

responsibilities, we suggest titles like ‘New Zealand Health Strategy’ rather than ‘HNZ Health Strategy’ would be a significant improvement.

When systems are complicated, definitions and titles are critical. Furthermore, plans should never sit above a strategy, so we want to emphasise again that hierarchies must also be clearly defined. Therefore the below statement in the 2022 law should change:

It currently reads: ‘Health New Zealand must give effect to the GPS [Government Policy Statement] and the New Zealand Health Plan when performing its functions’.

It should become: ‘Health New Zealand must give effect to the Government Policy Statement on Health Priorities and the New Zealand Health Strategy when performing its functions’. [underline shows new terms added]

## 2.2 Provide more clarity over who is responsible for which strategies

The Institute prepares the [GDS Index](#) every calendar year. Our focus is to include all strategy documents produced by government departments. Given HNZ is not a government department, new strategies published by HNZ will not be assessed in the GDS Index going forward. Once the many MOH published strategies are replaced by HNZ strategies, the GDS Index will reduce in size quite significantly. See Appendix 4 for a list of GDS Index strategies published by the Ministry of Health, and Appendix 6 for an extract of the relevant strategy *GDS Index* scorecards.

In this regard, we make the following observations:

- The Health sector budget is very significant,<sup>2</sup> yet it is not broken down into smaller budget units. This means strategies and plans are the key instrument for managing the delivery of this sector. Arguably it requires a higher level of control over deciding strategies and plans and reviewing their implementation and execution.
- According to the Institute’s GDS Index (which ranks strategy documents for transparency), MOH strategies rank highly, with four of the 27 strategies ranking in the top 12 (see Figure 1 below).
- We are aware many of the replacement plans published by MOH will move to HNZ and therefore will not be assessed under the GDS Index. We hope the legislation will build in a transparency approach to producing strategy documents. This may be something the committee considers should be embedded in law, for example, that the purpose and strategy (i.e. the strategic approach) must be clearly set out to show what a successful strategy, executed well, will deliver New Zealanders. This could, for example, be a template/cover sheet that goes with each HNZ strategy showing the lineage from the Government Goals, to the Government Policy Statement (GPS) priorities, to the New Zealand Health Plan (which we suggest should become a strategy). Alignment across and down the system is extremely important for those executing the strategy and/or monitoring/reporting on progress.
- If MOH sets policy and strategy and HNZ is responsible for the delivery of health services, why do strategies exist in the Pae Ora (Healthy Futures) Act 2022 but not in the Health Act 1956? We wonder if the current narrative is actually an accurate portrayal of current system.

**Figure 1: GDS Index Top 12 GDSs by the Transparency Scorecard**  
Source: McGuinness Institute<sup>3</sup>

**List A: GDSs in operation by rank order [195]**

Rank (out of 195 GDSs)	Score (out of 96)	GDS number	GDS title	Department	Sector	Publication date	Index when GDS added
1	90	GDS14-05	<i>Aotearoa New Zealand's First Emissions Reduction Plan</i>	14. Ministry for the Environment	Natural Resources Sector	May 2022	2023 GDS Index
2	87	GDS11-01	<i>Pacific Languages Strategy 2022-2032</i>	11. Ministry for Pacific Peoples	Social Services and Community Sector	August 2022	2023 GDS Index
3	85	GDS14-08	<i>Te Rautaki Para   Waste Strategy</i>	14. Ministry for the Environment	Natural Resources Sector	March 2023	2023 GDS Index
4	83	GDS04-06	<i>Te Rautaki Matihiko mō Aotearoa   The Digital Strategy for Aotearoa</i>	04. Department of Internal Affairs	Finance and Government Administration Sector	September 2022	2023 GDS Index
5	82	GDS21-24	<i>Rural Health Strategy</i>	21. Ministry of Health	Health Sector	July 2023	2023 GDS Index
6=	81	GDS21-20	<i>Health Strategy</i>	21. Ministry of Health	Health Sector	July 2023	2023 GDS Index
6=	81	GDS21-22	<i>Provisional Health of Disabled People Strategy</i>	21. Ministry of Health	Health Sector	July 2023	2023 GDS Index
8=	80	GDS02-13	<i>Climate Change Adaptation Plan   He Whakamahere Hātepe Urutau mō te Huringa Āhuarangi</i>	02. Department of Conservation	Natural Resources Sector	June 2020	2023 GDS Index
8=	80	GDS22-03	<i>MAIHI Ka Ora: The national Māori housing strategy</i>	22. Ministry of Housing and Urban Development	Social Services and Community Sector	December 2021	2023 GDS Index
8=	80	GDS23-01	<i>Te Aorekura: The national strategy to eliminate family violence and sexual violence</i>	23. Ministry of Justice	Justice Sector	December 2021	2023 GDS Index
8=	80	GDS25-09	<i>Te Aorekura: The national strategy to eliminate family violence and sexual violence</i>	25. Ministry of Social Development	Social Services and Community Sector	December 2021	2023 GDS Index
12=	78	GDS20-06	<i>International Climate Finance Strategy: Tuia te Waka a Kiwa</i>	20. Ministry of Foreign Affairs and Trade	External Sector	August 2022	2023 GDS Index
12=	78	GDS21-25	<i>Women's Health Strategy</i>	21. Ministry of Health	Health Sector	July 2023	2023 GDS Index

**Recommendation 5: Expand Schedule 1, Clause 51.**

Schedule 1, Clause 51’s requirement that the Minister must prepare and determine new health strategies within 24 months is exceedingly ambitious (and potentially unrealistic). Effective strategies take considerable time and effort in order to understand the problem, assess the landscape, identify trends and design a strategy to achieve its purpose. The timeline proposed in the Bill is likely to overwhelm officials and may lead to strategies that are not effective. We would instead recommend that many existing MOH strategies could be republished under the HNZ banner, and be revisited in three to five years’ time. This would enable strategies that currently do not exist to be given priority.

For this reason, we recommend the below:

- a. Replace 24 months with 36 months, or reduce the number of strategies to those that are considered more critical and/or very out of date within the 24-month period.
- b. Make the Mental Health and Wellbeing Strategy (under Clause 46A) a requirement to be published in 18 months (as we currently do not have a strategy on this topic).
- c. Add Schedule 1, Clause 51(g) *New Zealand Pandemic Plan* to the list and require it to be published in 12 months’ time. (We currently only have an interim plan, see bottom of table in Appendix 4.) We strongly suggest that, going forward, this be retitled as the ‘New Zealand Pandemic Strategy’. From our understanding, this document is not specified in any law (we have checked the Health Act 1956, the Epidemic Preparedness Act 2006 and the new 2022 Act). Given the impact of the pandemic, we consider this is a critical document that should be embedded and co-exist in the suite of health strategies. Pandemics should be seen as the normal business of MOH and HNZ. Integration is key.

- d. Add Schedule 1, Clause 51(h) *AI and Robots health care strategy* to the list and require it to be published in 18 months (as we currently do not have a strategy on this topic).
- e. There are a number of strategies in Appendix 4 that come under MOH. Some of these may be better placed under HNZ. We suggest a review is undertaken of each to see where they best sit. If we want cost-effective deliverables to New Zealanders, we need to ensure we have an integrated health care system. There is no doubt in our minds that this ad hoc and unsystematic approach to strategy and planning is costing New Zealanders money and delivering less effective health care. We need to systemise the health care system so that it pulls together rather than pushes the system apart.

Figure 2: Excerpts from the Bill

<p><b>50 Minister must issue new GPS within 18 months</b> The Minister must issue a new GPS under section 34 within 18 months after the commencement date.</p> <p><b>51 Minister must prepare and determine new health strategies within 24 months</b> The Minister must prepare and determine the following within 24 months after the commencement date:</p> <ul style="list-style-type: none"> <li>(a) a New Zealand Health Strategy under section 41:</li> <li>(b) a Hauora Māori Strategy under section 42:</li> <li>(c) a Pacific Health Strategy under section 43:</li> <li>(d) a Health of Disabled People Strategy under section 44:</li> <li>(e) a Women’s Health Strategy under section 45:</li> <li>(f) a Rural Health Strategy under section 46:</li> <li>(g) a Mental Health and Wellbeing Strategy under section 46A.</li> </ul> <p><b>52 Health New Zealand must develop new New Zealand Health Plan within 24 months</b> Health New Zealand must develop a new New Zealand Health Plan within 24 months after the commencement date.</p>
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### 2.3 Integrate pandemic preparedness

Recommendation 5(d) above suggests that Schedule 1, Clause 51(g) *New Zealand Pandemic Plan* should be added to the list and be required to be published in 24 months’ time.

Overall, we have a concern that, given it is now five years since the COVID-19 pandemic, we have failed to learn the lessons and put in place changes to strengthen our ability to withstand the next pandemic. In the last five years we have seen a significant decrease in expertise in the House (see Appendix 3 for more detail). Only 40% of MPs who were in the House in 2020 now remain; 36% of the Epidemic Response Committee remain; and 25% of the COVID-19 Ministerial Group remain. This means that Parliament, next time around, will be new to a pandemic and will be reliant on the changes this Government put into legislation to guide the next Government to deal with a pandemic. This places a significant responsibility on the committee and it is one we ask you to consider urgently.

To confirm, the need for a New Zealand Pandemic Plan is not currently mentioned in legislation at all.

Notably, the term pandemic itself is not mentioned in legislation either. Epidemics are largely mentioned in the Epidemic Preparedness Act 2006, and are only mentioned in the Health Act 1956 in regard to the epidemic notice. Most critically, neither the Pae Ora (Healthy Futures) Act 2022, nor the amendment, mentions the terms ‘pandemic’ or ‘epidemic’. We find this quite

shocking and expect other members of the public would also be surprised, and in some cases very frustrated and disappointed.

During the Institute's research we were concerned to note:

- The Health Act 1956 mentions epidemics briefly (17 times), but largely in terms of the Epidemic Preparedness Act 2006, and more specifically how and when to apply epidemic notice.
- The Pae Ora (Healthy Futures) Act 2022 (administered by MOH) and the proposed amendment do not mention pandemics or epidemics.
- The latest version of the Epidemic Preparedness Act 2006 is dated 4 November 2021.

Government, MOH and HNZ may argue that they are awaiting the results of Phase 2 of the COVID-19 Inquiry, but the second phase of the Inquiry is very narrow and will not comment on the response to the early stages of the pandemic. These stages and the subsequent lessons are covered in the first report which is already published.

Further, there is an assumption that we can afford to wait for the second report, but time may not be on our side. A new pandemic or epidemic will not wait for the results of the second phase of the Inquiry to be published and implemented. We should be acting on the findings of the Phase 1 Inquiry and they should be integrated into this legislation.

It is important to acknowledge that the most critical document, the New Zealand Pandemic Plan, was tweaked slightly in 2024, however, a full review was promised. The Institute has no knowledge on progress to date and we have prepared an OIA on this (see OIA 2025/11).<sup>4</sup>

It is relevant to note the 2024 New Zealand Pandemic Plan refers to actions authorised by statute. These statutes include the Health Act 1956, the Civil Defence Emergency Management Act 2002 and the Epidemic Preparedness Act 2006. The 2024 plan states:

The New Zealand Pandemic Plan refers to actions authorised by statute. These statutes include the Health Act 1956, the Civil Defence Emergency Management Act 2002 and the Epidemic Preparedness Act 2006.

The Health Act is the primary statute focused on the need to contain communicable diseases, within the country and at the border, and works alongside the more general Civil Defence Emergency Management Act. The Epidemic Preparedness Act provides additional legislative provisions prompted in part by emerging diseases such as SARS and influenza A (H5N1) and by the limitations of existing law.<sup>5</sup>

MOH prepared and published the 2024 *New Zealand Pandemic Plan A framework for action (Interim update – July 2024)*, which updates the 2017 *New Zealand Influenza Pandemic Plan: A framework for action*. It states:

The update is part of a wider review of pandemic preparedness taking place in two stages. This two-stage approach means the interim plan can reflect the changes in who does what in the health system since the 2022 health reforms and ensure those changed roles and responsibilities are clear if a new pandemic was to occur tomorrow. It focuses on goals, principles, key considerations and high-level roles and responsibilities.

Key changes include:

- Broadening the scope to cover respiratory-type pathogens of pandemic potential.
- Ensuring it is consistent with recent legislative changes, notably the 2022 health reforms.
- Reflecting Health New Zealand's role in leading the operational health response, the Ministry of Health's role in providing strategic and policy advice.

- Embedding some early lessons learnt from COVID-19 response, including the process for doing regular public health risk assessments and adopting a flexible testing approach.

The updated pandemic plan covers the health system response. It does not cover the all-of-government or wider societal response to a pandemic. **It is also only one tool for developing the health system’s preparedness and complements preparedness work across health services and wider society.** [bold added]<sup>6</sup>

As noted, this Bill does not recognise the pandemic plan/strategy as a strategy in Schedule 1, Clause 51(g) of the Bill. This would be an easy outcome for the committee to help ensure the plan integrates with other strategy documents. However, our hope is that the committee places pandemic preparedness at the top of the agenda for future amendments.

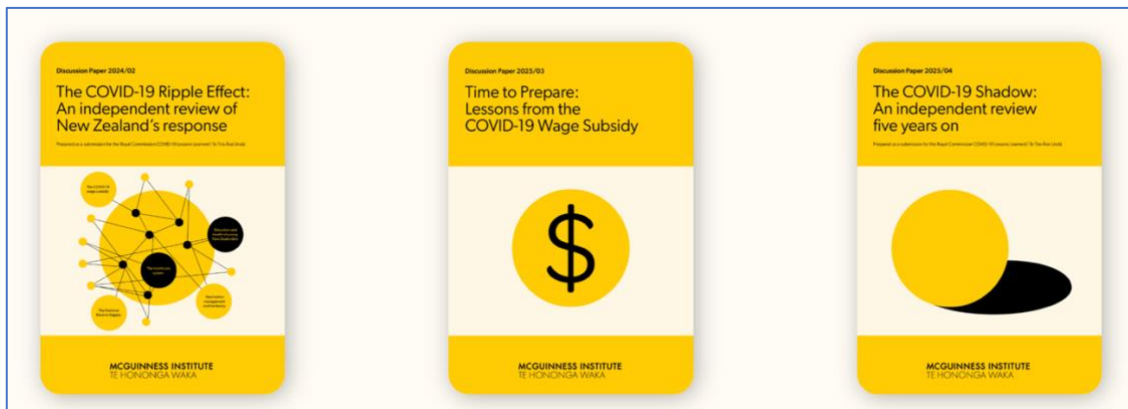
Furthermore, it brings into question why the New Zealand Influenza Pandemic Plan is not sitting in legislation at all, particularly given the significant impact it will have on society, now and in the future. See the table from Treasury’s Long-term Insights Briefing in Appendix 3.<sup>7</sup>

Although this does not directly relate to the Bill before the committee, the Institute has consistently recommended that a separate Cabinet committee be established to review all the pandemic and epidemic material, including preparedness exercises and the Phase 1 and 2 Inquiries, and put in place an annual review process in the House. This is to ensure a small number of members across the House have a clear understanding of the process, and are able to influence and improve the processes and policies that they may need to implement or support during a pandemic in the future.

To this end the Institute is in the process of preparing three reports that aim to contribute to this discussion. See Figure 3.

### Figure 3: Upcoming COVID-19 reports

Source: McGuinness Institute<sup>8</sup>



The Institute has also requested that the MOH publish a stocktake of critical items of supply for emergencies and crises. This is known as the National Reserve Stocktake (NRS). Although a report on stocks has been published by the MOH over three times (at least once before and twice during the pandemic), the MOH has said they will not publish it currently and MOH report they ‘have no intention of inviting public consultation or making the contents of the National Reserve Supply public.’<sup>9</sup> Given the stress that a strain on resources caused those on the frontline (e.g. nurses and doctors), we consider it is good practice to be transparent and invite feedback on its content. The Institute currently has a complaint with the Ombudsman on this matter.<sup>10</sup>

There is also considerable work that needs to be done to draw a distinction between the emergency response and the crisis response during the pandemic. This means that the work that is currently being progressed on emergency management needs to be considered by the Health Committee. Cabinet has recently agreed to a new Bill titled the Emergency Management Bill. It has currently been sent to the Parliamentary Counsel Office (PCO) for drafting and will replace the Civil Defence Emergency Management Act 2002.<sup>11</sup>

We have some research on this which is explored in an upcoming discussion paper, titled: *Discussion Paper 2025/02 – How to Tell the Difference Between an Emergency and a Crisis and Why it Matters*. See the cover of this report in Figure 4 below. We will send the committee a copy of the paper next week, however, a diagram from the paper is useful for asking whether we have the right infrastructure for the type of events we are likely to face in the future. See this diagram in Figure 5 below.

The Government's emergency powers are currently written up in the Clerk of the House of Representatives *Parliamentary Practice in New Zealand* online publication. The latest version is dated 29 September 2023.<sup>12</sup> Chapter 54, Emergency Powers, recognises that the:

Government may be required to exercise extraordinary powers when responding to an emergency situation. It is therefore essential that Parliament has oversight of the use of such extensive powers.<sup>13</sup>

The chapter explains how an emergency is managed in practice and has sections on both the Christchurch earthquakes and the COVID-19 pandemic. The definition of emergency in this context is that same as s 4 of the Civil Defence Emergency Management Act 2002.

Understandably, it is the Government's prerogative to lead the response to emergency.

States of national emergency are declared by the relevant Minister and expire after seven days. There is no limit on the number of renewals available to the Minister in charge. The House's agreement is not required for the declaration or extension of a state of national emergency, and it has no power to revoke a state of national emergency. However, the requirement to inform the House stands for each renewal.<sup>14</sup>

We consider more work needs to be done in terms of how we deal with a crisis, which has many different characteristics from an emergency.

**Recommendation 6: Embed pandemic preparedness and crisis management, publish monthly stocktakes of our National Reserve Supply (NRS), and establish a separate Epidemic/Pandemic Cabinet Committee to regularly review our preparedness.**

#### **2.4 Clarify the relationship between Government and officials and remove repetition of public service principles and obligations**

There is wording in the Bill that indicates Government does not trust officials, and this has resulted in repetition of public service principles which should not be in this Bill. For example, Clause 11A in the proposed amendment, stipulates not just the need to adopt the public service principles (which in our view is a given), but also, specifically, the principle of political neutrality (which also should be a given). We remain unsure why this is needed in this legislation if it is not required in other legislation that deals with other government departments and agencies. It is unclear why the Bill includes repetition of a standard public service principle. If this principle already exists once in law, it should be sufficient. HNZ is already in the list on the Public Service

Commission website that says that the public service principles must be adopted (they are not exempt).<sup>15</sup>

We also note, regarding s 20 of the Public Service Act 2020, that if political neutrality is required, there is an allowance in law for an official to express the right to express an opinion and an obligation to their profession. This would seem an acceptable way of dealing with those that have specific expertise. Creating a space for an opinion seems prudent, especially when dealing with health issues.

**Figure 6: Excerpts from the Bill**

<p><i>Clause 11 inserts new section 11A, which clarifies that the provisions of subparts 2 and 4 of Part 1 of the Public Service Act 2020 apply to Health New Zealand, its employees, board members, the chief executive, contractors, and secondees. These provisions include requirements for—</i></p> <ul style="list-style-type: none"><li>• Health New Zealand to uphold the public service principles, including the principle of political neutrality, when carrying out its functions; and</li><li>• 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.</li></ul>
<p><b>11A Obligations as Crown agent, including in relation to political neutrality</b></p> <p><i>See subparts 2 and 4 of Part 1 of the Public Service Act 2020, which—</i></p> <ul style="list-style-type: none"><li>(a) apply to Health New Zealand as a Crown agent and to groups and individuals in Health New Zealand, including its employees, board members, the chief executive, contractors, and secondees; and</li><li>(b) include requirements for—<ul style="list-style-type: none"><li>(i) Health New Zealand to uphold the public service principles, including the principle of political neutrality, when carrying out its functions; and</li><li>(ii) 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.</li></ul></li></ul>

**Figure 7: Excerpts from s 20 of the Public Service Act 2020**

<p><b>17 Commissioner may set minimum standards of integrity and conduct</b></p> <ul style="list-style-type: none"><li>(1) The Commissioner may set minimum standards of integrity and conduct, including standards relating to—<ul style="list-style-type: none"><li>(a) the public service values;</li><li>(b) the public service principles.</li></ul></li><li>(2) Those minimum standards may apply in or to—<ul style="list-style-type: none"><li>(a) the public service (including Crown agents);</li><li>(b) Crown entities (other than Crown agents and excluding tertiary education institutions, and Crown Research Institutes and their subsidiaries);</li><li>(c) companies named in Schedule 4A of the Public Finance Act 1989;</li><li>(d) the Parliamentary Counsel Office.</li></ul></li></ul>
<p><b>20 Required content of guidance on political neutrality</b></p> <ul style="list-style-type: none"><li>(1) If guidance issued under section 19 includes guidance on the public service principle of political neutrality, the guidance must address—<ul style="list-style-type: none"><li>(a) the right to freedom of expression; and</li><li>(b) the responsibilities of individuals who have obligations as a member of a profession.</li></ul></li><li>(2) In this section, <b>profession</b> means an occupational group with a registration requirement under an Act for the individuals who work or practise in the occupational group.</li></ul>

**Recommendation 7: Remove Clause 11A as it is repetitive and unconstructive.**

## 2.5 Keep equity as a guiding principle

It is of a significant concern that the Bill proposes to remove equity as a guiding principle of healthcare in New Zealand. This Bill removes legal obligations to address health inequities and dismantles proven mechanisms for improving Māori health outcomes. It is also concerning that removing equity is likely to have negative impacts on groups that need already face barriers to receiving healthcare, including children, Māori and Pacific peoples, older adults and those with physical and intellectual disabilities. We need to provide healthcare to everyone, and especially to support those who need it most.

There is already a gap between those who can access healthcare and those who cannot, and minority groups suffer from this gap the most. As the *Regulatory Impact Statement* says, 'It is widely recognised that Māori generally experience poorer health outcomes compared to non-Māori with disparities evident in health indicators concerning mortality rates, prevalence of chronic diseases and access to health care.'<sup>16</sup> This Bill risks further increasing the gap. A shared value of New Zealanders as a country is that we look after one another. All people should be able to receive quality, affordable (ideally free) healthcare.

The Bill has received criticism from a number of groups, including the Western Bay of Plenty Primary Health Organisation (a non-profit) as it 'disregards the recommendations from Wai 2575 (Waitangi Tribunal) Report and also reduces the decision-making role of Māori in the health system, downgrading Iwi-Māori Partnership Boards (IMPB) to advisory-only status.'<sup>17</sup>

Providing healthcare for those in need is an important part of health policy in New Zealand; it is not about race but about meeting the unique needs of citizens and supporting those who need it. For example children, older adults or those with disabilities will have unique needs that need to be identified and addressed. Some of those children or adults will need more support than others because they do not have the skills, capabilities or resources to support themselves. Including this principle deals with that disparity.

Life is not fair sometimes and we need to ensure the health system recognises that there are situations where New Zealanders are unlucky or have had to deal with a significant tragedy. At a time when the majority of New Zealanders are suffering from a cost of living crisis and increasing levels of unemployment, it is important healthcare is not limited to those who can afford to pay for private. We need a health system that supports these people.

Our view is that MPs do not become MPs without wanting to make the country a better place for current and future New Zealanders. For this reason, we expect the committee will find a way to include a sentiment for equity and compassion for others less fortunate. This principle must sit within the wider health care system – caring for people in need – but recognising those needs are different depending on the recipient (rather than from the perspective of the provider). Needs must be targeted to the needs of the individual.

### **Recommendation 8: Keep equity as a guiding principle.**

## 2.6 Remove emphasis on outsourcing care to the private sector and support public healthcare systems

This Bill facilitates outsourcing of healthcare to the private sector, which is concerning for a number of reasons. New Zealand's strained public healthcare systems should be supported rather than shifting work to the private sector. Healthcare should be available to all New Zealanders, not just those who can afford it. New Zealand already has a relatively small healthcare system when compared to international counterparts, and outsourcing care to the private sector will only further fragment this already small, strained system.

In May 2024, RNZ reported on a Health NZ memo to the minister, warning that the high level of outsourcing would hasten an exodus of medical professionals from the public system.<sup>18</sup>

Healthcare professionals have expressed serious concern about the implications of outsourcing significant numbers of surgeries to the private sector.<sup>19</sup> The Australian and New Zealand College of Anaesthetists warns that 'outsourcing would worsen medical workforce shortages and could create a two-tier health system.' As well as this, the chair of the college's New Zealand national committee, Graham Roper, said outsourcing will have negative impacts on trainee anaesthetists as they need access to the surgeries that were outsourced.<sup>20</sup> Roper said, 'If the trainees don't get what we call a volume of practise, so a number of cases in particular areas of work, then their training gets extended until they reach that number. So potentially the training will become longer and that will make it less attractive for junior doctors that are looking for a career.'<sup>21</sup>

**Figure 8: Excerpt from the Bill (under the Explanatory Note General Policy Statement)**

<p style="text-align: center;"><i>Refocusing purpose, objectives, and functions of Health New Zealand</i></p> <p>To refocus the purpose, objectives, and functions of Health New Zealand, the Bill makes the following changes:</p> <ul style="list-style-type: none"><li>• adding a new purpose of the Act, which is to ensure that patients get quality and timely access to health services:</li><li>• repealing the health sector principles and the New Zealand Health Charter:</li><li>• adding a new objective for Health New Zealand to deliver effective and timely services:</li><li>• clarifying that a function of Health New Zealand is to work with private healthcare providers.</li></ul>
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**Recommendation 9: Support the public healthcare system rather than outsourcing care to the private sector.**

## 2.7 Ensure the health system is a learning system

**There is a lack of any international examples to show where similar legislation has worked to provide positive healthcare benefits, to identify what hasn't worked, and how New Zealand can incorporate these lessons.** It is prudent to see what our trading partners are doing in this space, and this information should be publicly available. Good research is sorely needed, including understanding what is working (or not working) in other similar countries (e.g. UK, Australia and Canada).

**Recommendation 10: Undertake and share international analysis so our Bill can be consistent with international standards, and so that we can learn from our international partners.**

## 2.8 Prepare for the impacts of AI in legislation and on our health system

The Institute recommends that all new legislation should be designed in ways that anticipate and prepare for how AI can be implemented in digital systems. For example, digital implementation assets (such as data structures, reporting templates, or decision trees) can be published alongside legislation to illustrate its intended effect. Any legislative system that requires reporting digital data presents particularly significant opportunities.

The below are three aspects of AI that we consider relevant to this submission:

### 1. Developments in AI should be included any new legislation.

Developments in technology, especially AI, will have significant impacts on the healthcare system and our legislation should prepare for this. AI (and robots using AI) will significantly impact healthcare in the near future. There will be risks and benefits, and we need to understand how to ensure the healthcare system uses AI and robots to deliver optimal outcomes for New Zealanders.

We recommend that New Zealand looks to international examples of how AI, robots and technology have been used for healthcare services internationally. Singapore provides two recent examples of how AI and technology can benefit patients in the public healthcare system:

#### a) Singapore's Ministry of Health announces it will transform healthcare through technology, including AI (Oct 2024)

Singapore's MOH shared a press release of upcoming plans for new developments in healthcare and technology to help improve health outcomes:

In response to the convergence of three major developments, namely genomics, artificial intelligence (AI) and the focus on preventive care, the Ministry of Health (MOH) is seizing the opportunity to transform healthcare through technology. This will be done by: i) applying AI in health institutions; ii) developing predictive preventive care; and iii) building up the IT infrastructure systems to enable these capabilities.

MOH has partnered with the Health Promotion Board (HPB), Synapxe, the public healthcare clusters (National Healthcare Group, National University Health System, and SingHealth), and national clinical translational programmes, to leverage cutting-edge technology while maintaining public trust in and security of Singapore's healthcare system.<sup>22</sup>

#### b) AI assistance to be rolled out on Singapore's national healthcare system (June 2025)

At the inaugural AI Accelerate conference (organised by national healthcare tech provider Synapxe), it was announced that a number of AI developments are being developed by the public sector, including chatbot that breaks down the jargon in medical reports and an app that assesses patient health by analysing a photo of their tongue. These innovations are working to both help patients and boost the productivity of healthcare workers.<sup>23</sup>

### 2. Government documents should be verified independently.

For instance, in terms of regulation, this may mean that government documents need to be verified through AI processes. In May 2025, the Institute published *Think Piece 43: Unlocking Government documents with AI*.<sup>24</sup> This think piece explores what AI could look like when applied to Government documents, and in particular, how AI might provide taxpayers more value in terms

of delivering quality products and services. Improvements are possible not just in terms of delivering goods and services to citizens, but also delivering a more interconnected and aligned policy ecosystem, and any new legislation should consider this.

### **3. How AI is used in the submission process should be clarified and shared with the public.**

Further, we emphasise there are serious concerns with a lack of information on how AI is used in the submission process. If Parliament wishes to assure citizens that democratic processes are in place to deal with complex issues, it is important to be transparent about how technology is used in public processes.

Going forward, the Institute recommends that all Cabinet Committees and government departments using AI to collate and analyse submissions should be required to:

- declare their intention to use AI in advance, and
- clarify how AI will be used (to let submitters prepare submissions in ways that are accessible to AI systems, or choose not to submit if they do not want to, or choose alternative submission methods).

Some further recommendations on the use of AI in designing policy include:

1. AI should not be used to identify duplicate submissions without rigorous assurance mechanisms in place. The summary should clarify whether duplicate submissions were identified using AI (based on statistical similarity) or programmatic methods (exact duplication of files). The risk of false positives using AI to identify duplicate submissions is unacceptably high.
2. Where AI systems are used (for example to classify whether a submission is from an individual or organisation, or whether it is a duplicate) standard transparency procedures should require that the exact model used and the date of the analysis is recorded and published. This is because AI systems can change and develop over time, particularly where they are hosted remotely, and it may be necessary to revisit analyses later.
3. Data quality and formats are particularly important when it comes to the use of AI systems. For example, submitting a PDF that requires OCR (optical character recognition) will result in transformation and interpretation of the source document into other formats. This presents a risk of error that must be controlled for. By contrast, submissions received as text files or emails (or as structured datasets) are directly accessible to AI systems, and risks associated with OCR and PDF interpretation are mitigated. The summary of how submissions were processed should include a breakdown of the formats used and whether these included the use of OCR before they were submitted to the relevant AI system.

Parliament and officials need to work a lot harder in this space to maintain the public's trust in democracy.

### **Recommendation 11: Design legislation which incorporates futures-thinking, including AI.**

## 2.9 Improve public health by including legislation on how to respond to antibiotic resistance.

Unfortunately, New Zealand is experiencing high rates of antibiotic resistance due to a high rate of prescription and use. This will have serious implications on healthcare in New Zealand, and will have negative impacts across the community.

We refer to the 2024 paper *Reducing the spread of antibiotic resistance in New Zealand, action is long overdue!*, which reflects on why antibiotic resistance should be an immediate concern in New Zealand's healthcare strategy:

An unavoidable consequence of the high rate of community antibiotic use in NZ is that the prevalence of antibiotic resistance in common bacterial pathogens is much higher than in other countries where antibiotics are less frequently prescribed for illnesses for which they provide no benefit.

Influential healthcare leaders in NZ, such as Te Whatu Ora and the Royal New Zealand College of General Practitioners, should set goals to strongly encourage sustained cumulative reductions in inappropriate antibiotic prescribing. Evidence from other countries shows that large reductions in community antibiotic use can be achieved without adverse consequences.

Failure to dramatically reduce inappropriate antibiotic prescribing in NZ will impose a high cost in increased death and disability from untreatable bacterial infections in the coming decades. This cost will inevitably fall hardest on those communities with the highest overall rates of antibiotic use, currently Pacific and Māori whānau.<sup>25</sup>

### **Recommendation 12: Design legislation which includes how to deal with antibiotic resistance.**

## 2.10 Improve public accountability in healthcare with a Monthly Healthcare Dashboard of key metrics.

To clearly communicate with the public the state of the healthcare system, we recommend that a Monthly Healthcare Dashboard is shared publicly. A dashboard would include key metrics, such as the state of the workforce (including number of people entering and exiting the workforce), health system resources, and quality of care (measured by metrics including the number of surgeries, waiting times, etc).

We can only manage what we measure. Including a policy requirement for a Monthly Healthcare Dashboard will allow for comparison between governments and will help us learn how to improve our healthcare system. We will be able to observe issues and manage them quickly, resulting in optimal healthcare for patients. More information will allow us to analyze the past and prepare for the future.

### **Recommendation 13: Require the creation of a Monthly Healthcare Dashboard that sets out the status of the healthcare system.**

## 3.0 Conclusion

This Bill is unclear on how it will solve any healthcare problems in New Zealand and, in fact, has the potential to cause problems through a lack of clarity and potential unintended consequences, meaning those who need healthcare may not be able to access it.

The McGuinness Institute recommends this Bill should not be passed as it currently stands. It requires much more detailed research and analysis before the policy framework can be designed to deliver benefits to New Zealanders. We outline below our 12 recommendations:

- **Recommendation 1: Clauses 34-40 Government Policy Statement on Health should be renamed to add priorities to the title, so it reads ‘Government Policy Statement on Health Priorities’.**
- **Recommendation 2: Clause 50 New Zealand Health Plan, should be renamed ‘Health New Zealand Strategy’.**
- **Recommendation 3: Clause 55 Locality Plans, should be renamed ‘Health New Zealand Local Strategies’.**
- **Recommendation 4: Clause 41 New Zealand Health Strategy and Clauses 50–53 New Zealand Health Plan should be merged into one document – ‘Health New Zealand Strategy’ – as the distinction between the two is unclear.**
- **Recommendation 5: Expand Schedule 1, Clause 51.**
- **Recommendation 6: Embed pandemic preparedness and crisis management, publish monthly stocktakes of our National Reserve Supply (NRS), and establish a separate Epidemic/Pandemic Cabinet Committee to regularly review our preparedness.**
- **Recommendation 7: Remove Clause 11A as it is repetitive and unconstructive.**
- **Recommendation 8: Keep equity as a guiding principle.**
- **Recommendation 9: Support the public healthcare system rather than outsourcing care to the private sector.**
- **Recommendation 10: Undertake and share international analysis so our Bill can be consistent with international standards, and so that we can learn from our international partners.**
- **Recommendation 11: Design legislation which incorporates futures-thinking, including AI.**
- **Recommendation 12: Design legislation which includes how to deal with antibiotic resistance.**
- **Recommendation 13: Require the creation of a Monthly Healthcare Dashboard that sets out the status of the healthcare system.**

## Endnotes

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