MINISTRY OF HEALTH
MANATŪ HAUORA

New Zealand Government

Briefing to the Incoming Minister

Part B: The New Zealand Health and Disability System – Handbook of Organisations and Responsibilities

2020

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System overview

Overview and introduction

The Minister of Health (the Minister), with Cabinet and the government, develops policy for the health and disability sector and provides leadership. The Minister is principally supported and advised by the Ministry of Health (the Ministry) and ministerial advisory committees.

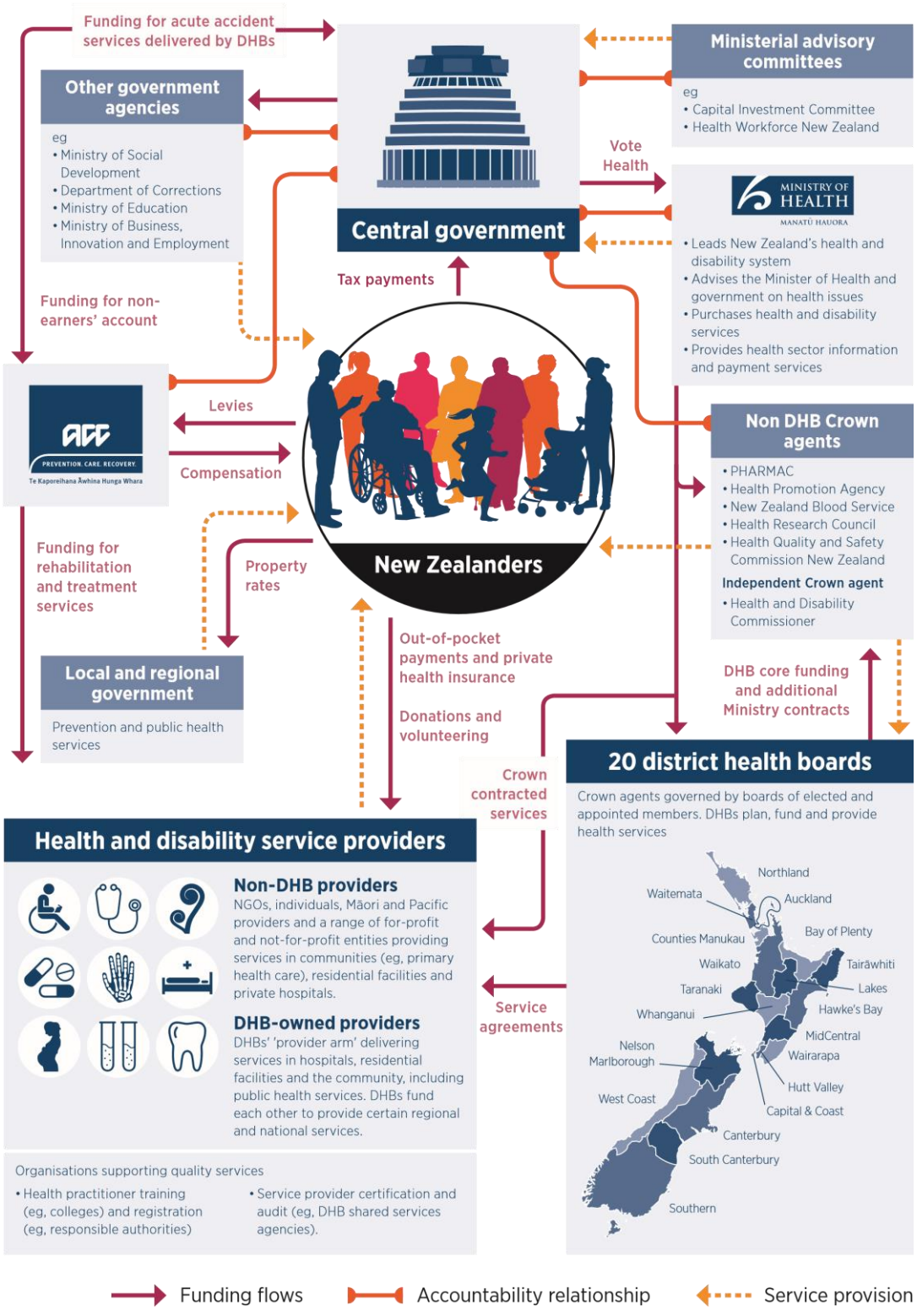
The New Zealand Health Strategy sets the direction of services to improve the health of people and communities. It lays out some of the challenges and opportunities the system faces and describes the future we want, including the culture and values that will support this future. The health and disability system is committed to fulfilling the special relationship between Māori and the Crown under Te Tiriti o Waitangi. This is necessary to realise the overall aims of He Korowai Oranga – Māori Health Strategy and see all New Zealanders living longer, healthier and more independent lives.

District health boards (DHBs) administer most of the day-to-day business of the system and nearly three-quarters of the funding. DHBs plan, manage, provide and purchase health services for the population of their district, implement the government's health and disability policy and arrange effective and efficient services for all New Zealand. This includes funding for primary health care, hospital services, public health services, aged care services, mental health and addiction services and services provided by non-government health providers, including Māori and Pacific providers.

In addition to acting as the government's principal advisor on health and disability policy and supporting the Minister, the Ministry has a range of stewardship roles in the system. It funds an array of national services (including disability support and public health services); provides clinical and sector leadership; and has monitoring, regulatory and protection functions.

The system extends beyond the Ministry and DHBs to ministerial advisory committees, the Accident Compensation Corporation (ACC), other health Crown entities, primary health organisations (PHOs), public health units (within some DHBs), private providers (including Māori and Pacific providers) and general practitioners (GPs). It includes professional and regulatory bodies for all health professionals, including medical and surgical specialties, nurses and allied health groups. There are also many non-government organisations (NGOs) and consumer bodies that provide services and advocate for the interests of various groups.

Figure 1: Overview of the New Zealand health and disability system



Overview of Vote Health

Vote Health (the Vote, worth $20.269 billion in 2020/21) is a significant public investment in the wellbeing of New Zealanders and their families. The Vote directly supports the day-to-day operation of strong and equitable public health and disability services delivered by a skilled workforce in our communities, hospitals and other care settings.

The Vote plays a key role in supporting population health, including improving health equity for Māori and other groups. It helps deliver key system priorities including child wellbeing, mental wellbeing, wellbeing through prevention and primary health care. The Minister is responsible for appropriations for 2020/21 covering:

- $15.274 billion (or 75.4 percent of the Vote) provided to the 20 DHBs for services to meet the needs of each district's population, allowing for regional considerations, government priorities and the strategic direction set for the health sector. Among the services provided or funded by DHBs are hospital services; most aged care, mental health and primary care services; the combined pharmaceuticals budget; and some public health services
- $3.760 billion (or 18.6 percent of the Vote) funding for health and disability services, funded at a national level and managed by the Minister, consisting of:
  - national disability support services ($1,707 million or 8.5 percent of the Vote)
  - public health service purchasing ($469 million or 2.3 percent of the Vote)
  - national planned care services ($425 million or 2.1 percent of the Vote)
  - primary health care strategy ($367 million or 1.8 percent of the Vote)
  - national mental health services ($208 million or 1.0 percent of the Vote)
  - national maternity services ($205 million or 1.0 percent of the Vote)
  - national emergency services ($148 million or 0.7 percent of the Vote)
  - national child health services ($112 million or 0.6 percent of the Vote)
  - national personal health services ($67 million or 0.3 percent of the Vote)
  - other national services ($52 million or 0.3 percent of the Vote).
- $529 million (2.6 percent of the Vote) for the support, oversight, governance and development of the health and disability sector, consisting of:
  - Ministry operating costs ($250 million or 1.2 percent of the Vote)
  - health workforce training and development ($219 million or 1.1 percent of the Vote)
  - monitoring and protecting health and disability consumer interests ($26 million or 0.1 percent of the Vote)
  - other services ($34 million or 0.2 percent of the Vote).
- $55 million (or 0.3 percent of the Vote) for other expenses, including $45 million for provider development

- $651 million (3.1 percent of the Vote) for capital investment, consisting of:
  - sector capital investment ($583 million or 2.9 percent of the Vote)
  - equity support for DHB deficits ($39 million or 0.2 percent of the Vote)
  - residential care loans ($20 million)
  - Ministry capital expenditure ($9 million).

Information on the financial impact of COVID-19 on Vote Health will be provided as a separate briefing.

Statutory framework

The health and disability system's statutory framework is made up of more than 25 pieces of legislation. The most significant pieces of legislation are the New Zealand Public Health and Disability Act 2000, the Health Act 1956, the Crown Entities Act 2004, the Epidemic Preparedness Act 2006 and the COVID-19 Public Health Response Act 2020. Legislation administered by the Ministry and other regulatory roles are listed in Appendix 1.

The **New Zealand Public Health and Disability Act 2000** establishes the structure for public sector funding and the organisation of health and disability services. It mandates the New Zealand Health Strategy and New Zealand Disability Strategy, establishes DHBs (including their geographical areas) and certain other health Crown entities and sets out the duties and roles of key participants, including the Minister and ministerial advisory committees.
The **Health Act 1956** sets out the roles and responsibilities of individuals to improve, promote and protect public health, including the Minister, the Director of Public Health and designated officers (eg, Medical Officers of Health and Health Protection Officers). It contains provisions for the management or regulation of environmental health, infectious and notifiable diseases (including quarantine), artificial UV tanning services, health emergencies and the National Cervical Screening Programme. This Act enables many of the powers exercised during the COVID-19 response.
The **Crown Entities Act 2004** provides the statutory framework for the establishment, governance and operation of Crown entities. It clarifies accountability relationships and reporting requirements between Crown entities, their boards and members, monitoring departments, responsible Ministers and Parliament.
The **Epidemic Preparedness Act 2006** provides for the issuing of an 'Epidemic Notice' that grants special powers in an epidemic situation, including amending primary legislation by the executive. An Epidemic Notice was issued by the Prime Minister under the Act on 23 March 2020 to support New Zealand's response to COVID-19.
The **COVID-19 Public Health Response Act 2020** was passed as standalone legislation to provide a different legal framework for responding to COVID-19. The Act allows the Minister of Health (or the Director-General of Health in specified circumstances) to make orders under section 11 to give effect to the public health response to COVID-19 in New Zealand.

Ministerial advisory committees

Ministerial advisory committees provide the Minister with independent expert advice on specific subject matter areas according to their terms of reference and offer a forum for representatives of the sector to have a role in decision-making.

Section 11 of the New Zealand Public Health and Disability Act 2000 allows the Minister to establish advisory committees. Under section 16 of the Act, the Minister **must** appoint a national advisory committee on the ethics governing health and disability support services (the National Ethics Advisory Committee). The Minister can also establish ad hoc committees as required.

Section 11 Ministerial advisory committee	Description
Initial Mental Health and Wellbeing Commission	The Initial Mental Health and Wellbeing Commission was established as part of the response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. It provides independent scrutiny of the Government's progress in improving New Zealand's mental health and wellbeing and promotes collaboration between entities that contribute to mental health and wellbeing. It will also develop advice for the permanent Mental Health and Wellbeing Commission, allowing it to make swift progress once established. The Chair, Hayden Wano, and the Members of the Initial Commission commenced their terms on 1 November 2019. The Initial Commission will be in place until the permanent Commission is established as an independent Crown entity in February 2021. The legislation to establish the permanent Commission has passed and the chair of the new commission will need to be appointed immediately post-election.
Capital Investment Committee	The Committee provides advice to the Ministers of Health, the Minister of Finance and the Ministry on capital investment and infrastructure in the public health sector. This includes working with DHBs to review their business case proposals, prioritisation of capital investment and delivery of a National Asset Management Plan and any other matters that the Minister may refer to it. The Chair of the Committee is Evan Davies, Managing Director, Todd Property.
Health Workforce Advisory Board	The Board advises the Minister on health workforce matters, including strategic direction, emerging issues and risks. It is chaired by Professor Judy McGregor. It was established in 2019 and replaced the former Health Workforce New Zealand committee.
Ministerial advisory committee for implementation of the Health and Disability System Review	The Government is preparing to appoint a ministerial advisory committee to advise the group of Ministers overseeing the implementation of the Health and Disability System Review. Terms of Reference have been approved by Cabinet. Appointments have not yet been finalised. While the appointments fall under the Health portfolio, the response to the Review is being led by the Department of the Prime Minister and Cabinet.
Contact Tracing Assurance Committee	The Committee provides independent advice to the Minister of Health on how the Ministry is making improvements to the contact tracing system recommended in Dr Ayesha Verrall's audit report, including advice on any national changes required to strengthen national contact tracing. All of Dr Verrall's recommendations have been implemented. Committee appointments conclude in May 2021. With Ministerial agreement, the Committee could be wound up.

Other ministerial advisory committees

Approximately 30 other committees, groups and forums provide additional advice to the Minister, some of which are described in Appendix 2.

Associate Ministers' portfolios

Associate Ministers are appointed to provide portfolio Ministers with assistance in carrying out their portfolio responsibilities. The Minister of Health determines the responsibilities that could be delegated to the Associate Ministers of Health. The former Minister of Health delegated areas of responsibility to three Associate Ministers of Health.

The Ministry can provide information on how portfolio responsibilities have been divided in the past on request.

Crown entities and departmental agencies

Crown entities are defined under the Crown Entities Act 2004 as entities that fall within five broad categories that include statutory entities (ie, Crown agents, autonomous Crown entities and independent Crown entities).

Establishing a Crown entity reflects a decision by Parliament that some functions should be carried out at 'arm's-length' from Ministers. Despite this distance, Ministers answer to Parliament for overseeing and managing the Crown's interests in, and relationships with, the Crown entities in their portfolios.

The Ministry takes a portfolio approach to managing relationships with health sector Crown agencies, with a lead Deputy Director-General assigned to each as a single point of contact/escalation.

The Ministry also hosts one departmental agency, Te Aho o Te Kahu (the Cancer Control Agency). A departmental agency is an operationally autonomous agency with its own chief executive, which is hosted by a Public Service department.

The table summarises the 26 statutory entities in the Health portfolio.

Table 1: Health portfolio Crown entities, office holders and chief executives

Type	Entity	Chair	Deputy Chair	Chief Executive
Crown agents *Crown agents must give effect to policy that relates to the entity's functions and objectives if directed by the Minister. The Minister appoints board members and has the power to remove a board member from office at his or her discretion.*	DHBs (20)	See DHBs section below		
	Health Promotion Agency	Jenny Black	Dr Monique Faleafa	Tane Cassidy
	Health Quality & Safety Commission	Dr Dale Bramley	Raewyn Lamb	Dr Janice Wilson
	Health Research Council of New Zealand	Dr Lester Levy	N/A	Professor Sunny Collings
	New Zealand Blood Service	David Chamberlain	Dr Jackie Blue	Sam Cliffe
	Pharmaceutical Management Agency (PHARMAC)	Hon Steve Maharey	Dr Jan White	Sarah Fitt
Independent Crown entity *Independent Crown entities are not subject to government policy directions unless specifically provided for in legislation. Board members are appointed by the Governor-General on the advice of the Minister, and may be dismissed by the Governor-General for 'just cause', on the advice of the Minister, in consultation with the Attorney-General.*	Health and Disability Commissioner	Morag McDowell (Commissioner)	Kevin Allan (Mental Health Commissioner – this role will cease in February 2021 with the establishment of the Mental Health and Wellbeing Commission) Rose Wall (Deputy Commissioner, Disability)	N/A
	Mental Health and Wellbeing Commission (from 9 February 2021)	TBC	TBC	TBC

Board appointments

The Minister appoints the chair, deputy chair and members of the Health Promotion Agency, Health Quality & Safety Commission, Health Research Council, New Zealand Blood Service and PHARMAC. The Governor-General appoints the Health and Disability Commissioner and Deputy Commissioners on the advice of the Minister.

Board members are typically appointed for a three-year term of office and the Health and Disability Commissioner and Deputy Commissioners are normally appointed for five-year terms. Vacant positions can be filled by the Minister at any time. The Minister can consider incumbents for reappointment. In some cases, enabling legislation sets out the position on reappointment and a maximum number of terms.

The Ministry prepares candidate selection papers to assist with ministerial decision-making and provides the Cabinet papers required to complete the appointment process. Appointment papers generally go through the Cabinet Appointments and Honours Committee before proceeding to Cabinet. Following confirmation from Cabinet, the responsible Minister/Associate Minister's office sends letters to successful and unsuccessful candidates.

Accountability and performance

Crown entities have a range of accountability documents in place to guide and monitor their performance. The Ministry monitors Crown entity performance on behalf of the Minister and entities file (at a minimum) quarterly performance reports. Some additional performance and accountability measures exist for DHBs, which are also audited annually.

Annual Letter of Expectations

The Minister provides a Letter of Expectations to all health Crown entities each year. This letter sets out the Government's strategic priorities and specific expectations for Crown entities.

Enduring Letter of Expectations

The Minister of Finance and the Minister of State Services issue an Enduring Letter of Expectations periodically to all Crown entities. This letter sets out more general expectations, including the need to engage with Māori, deliver strong performance and achieve value for money.

Statement of Intent and Statement of Performance Expectations

These documents set the entity's strategic intentions and medium-term undertakings, outline how the entity's funding will be allocated across services and determine performance targets and indicators. Entities are accountable to Parliament via their Statement of Intent and Statement of Performance Expectations. The Statement of Performance Expectations is tabled in Parliament at the beginning of the financial year and the Statement of Intent is produced and tabled every three years.

Output Agreement

This is the principal agreement between the Minister and each entity. It refers to entity-specific agreed performance targets as set out in the Statement of Performance Expectations and details funding and key aspects of the Ministry's relationship with the entity. DHBs' Output Agreements are known as Crown Funding Agreements.

Annual Report

This report sets out the entity's performance in achieving the goals, indicators and targets contained in its Statement of Intent and Statement of Performance Expectations and how the funding was actually allocated.

Directions

Policy directions

The Minister may give one or more Crown entities a direction to give effect to Government policy relating to the entity's functions and objectives, but may not give direction relating to a 'statutorily independent function' or requiring 'the performance or non-performance of a particular act, or the bringing about of a particular result, in respect of a particular person or persons'.

Crown agents must 'give effect to' legitimate policy directions and autonomous Crown entities must 'have regard to' them. The Minister cannot give an independent Crown entity a policy direction unless an Act specifically provides for this. There is no ability to give a policy direction to Crown-owned companies.

Whole of government directions

Under section 107 of the Crown Entities Act 2004, the Minister of State Services and the Minister of Finance may jointly direct Crown entities to support a whole-of-government approach by complying with specified requirements.

Whole-of-government directions can apply to categories of Crown entities (eg, all statutory entities), types of statutory entity (eg, Crown agents) or a group of entities with common characteristics (eg, DHBs; health sector Crown entities).

DHB-specific directions

The Minister has additional direction-giving powers under the New Zealand Public Health and Disability Act 2000 with respect to DHBs (see page 26).

Crown agents

District health boards

There are currently 20 DHBs. DHBs implement the health policies of the Government and provide or fund the provision of health services in their districts. See the DHBs section for detailed information.

Health Promotion Agency – Te Hiringa Hauora

The Health Promotion Agency was formed on 1 July 2012 through the merger of the Alcohol Advisory Council of New Zealand and the Health Sponsorship Council. The Health Promotion Agency also incorporated some health promotion functions previously delivered by the Ministry.

The Health Promotion Agency leads and delivers innovative, high-quality and cost-effective programmes that promote health; wellbeing and healthy lifestyles; disease prevention; and illness and injury prevention. This includes providing advice and recommendations to Government, government agencies, industry, non-government bodies, communities, health professionals and others on the supply, consumption and misuse of alcohol. The Health Promotion Agency also researches the use of alcohol in New Zealand, public attitudes toward alcohol and problems associated with alcohol misuse.

The Health Promotion Agency is funded from Vote Health, as well as the levy on alcohol produced or imported for sale in New Zealand and part of the problem gambling levy.

Table 2: Health Promotion Agency – Te Hiringa Hauora financial summary

Measure	Actual ($m) 2018/19	Forecast ($m) 2019/20	Budget ($m) 2020/21
Income	30.282	33.972	27.758
Expenditure	30.892	32.972	28.758
Surplus/(deficit)	(0.610)	1.000	(1.000)
Equity	3.530	3.658	2.658

Health Quality & Safety Commission

The Health Quality & Safety Commission was established in December 2010. It leads and coordinates work across the health and disability sector to monitor and improve the quality and safety of health and disability support services.

The Health Quality & Safety Commission advises the Minister on improving the quality and safety of health and disability support services and determines and reports quality and safety indicators (such as serious and sentinel events). It also has a range of functions relating to mortality, including appointing and supporting mortality review committees.

Table 3: Health Quality & Safety Commission financial summary

Measure	Actual ($m) 2018/19	Forecast ($m) 2019/20	Budget ($m) 2020/21
Income	17.849	18.902	18.709
Expenditure	18.285	18.982	19.154
Surplus/(deficit)	(0.436)	(0.080)	(0.445)
Equity	1.788	1.708	1.263

Health Research Council of New Zealand

The Health Research Council of New Zealand is the principal government funder of health research. It was established under the Health Research Council Act 1990 and is responsible to the Minister. The Health Research Council advises Ministers on priorities for health research and health research policy; initiates and supports health research; negotiates and administers health research funding; fosters health research workforce development; and promotes and disseminates health research findings.

The Health Research Council funds health research in four broad areas:

- health and wellbeing in New Zealand – keeping New Zealanders healthy and independent for longer
- improving outcomes for acute and chronic conditions – understanding, prevention, diagnosis and management of acute and chronic conditions
- New Zealand health delivery – improving service delivery
- rangahau hauora Māori – improving Māori health outcomes and quality of life.

It also offers career development awards to support the growth of skills and diversity in the health research workforce.

All research funded by the Health Research Council must respond to the New Zealand Health Research Prioritisation Framework, which was developed under the *New Zealand Health Research Strategy 2017-2027* and released in December 2019. This Framework sets out why and how health research needs to be done in New Zealand and seeks to connect, coordinate and focus resources on research that will bring the greatest benefits in health and wellbeing.

The Ministry works closely with the Health Research Council on implementing the *New Zealand Health Research Strategy 2017-2027*. It also has an enduring partnership agreement with the Health Research Council to invest in areas that will address key knowledge gaps for policy development and service provision.

The Health Research Council is largely funded from Vote Science and Innovation. A Memorandum of Understanding governs the relationship, in which the Minister and the Minister of Research, Science and Innovation work closely together to provide direction and set expectations.

Table 4: Health Research Council financial summary

Measure	Actual ($m) 2018/19	Forecast ($m) 2019/20	Budget ($m) 2020/21
Income	110.478	127.126	127.031
Expenditure	112.351	123.333	126.928
Surplus/(deficit)	(1.873)	3.560	103
Equity	9.149	12.71	11.923

New Zealand Blood Service

The New Zealand Blood Service ensures the supply of safe blood products. It provides an integrated national blood transfusion process, from the collection of blood from volunteer donors to the provision of blood products within the hospital environment. The New Zealand Blood Service is funded through the sale of blood products to DHBs. In 2020/21, the New Zealand Blood Service will begin coordinating the organ donation function, taking over from a unit within Auckland DHB.

Table 5: New Zealand Blood Service financial summary

Measure	Actual ($m) 2018/19	Forecast ($m)* 2019/20	Budget ($m) 2020/21
Income	133.075	140.783	161.674
Expenditure	133.668	147.228	163.107
Surplus/(deficit)	(0.593)	(6.445)	(1.435)
Equity	38.239	31.794	34.672

* Note that for 2020/21 Government approved $7.0m in equity and $3.97m in revenue from the COVID-19 Response and Recovery Fund for the New Zealand Blood Service.

Pharmaceutical Management Agency (PHARMAC)

PHARMAC has a legislative objective to secure the best health outcomes that are reasonably achievable from pharmaceutical treatment for eligible people in need of pharmaceuticals from within the funding provided.

PHARMAC manages the Pharmaceutical Schedule, which applies consistently across New Zealand, and decides which medicines, therapeutic medical devices and related products are publicly funded; who can prescribe them to enable them to be funded; and who can access them.

PHARMAC manages a fixed budget, called the Combined Pharmaceutical Budget (CPB), which the Minister determines annually after receiving advice from PHARMAC and DHBs. The funding sits within the appropriations to DHBs. The CPB value for 2020/21 will be $1.045 billion.

PHARMAC has a unique business model that creates competition among the suppliers of pharmaceuticals. This model has enabled huge savings. Taking into account medicine price decreases, PHARMAC's purchasing power has tripled since 1993. Since 2000, the benefits have been estimated as at least $5 billion in reduced expenditure.

PHARMAC also has a role in public hospitals, making decisions on which medicines may be used and negotiating national contracts for hospital medical devices. It is working towards managing fixed budgets for hospital medicines and medical devices, which is a vital component of its business model.

PHARMAC's main roles include:

- managing a pharmaceutical schedule that applies consistently throughout New Zealand, including determining eligibility and criteria for the provision of subsidies
- managing incidental matters, including providing subsidies for the supply of pharmaceuticals not on the pharmaceutical schedule in exceptional circumstances
- engaging in research to meet its objectives
- promoting the responsible use of pharmaceuticals.

Table 6: PHARMAC financial summary

Measure	Actual ($m)* 2018/19	Forecast ($m)* 2019/20	Budget ($m) 2020/21
Income	36.507*	28.098	27.951
Expenditure	26.684	26.647	29.056
Surplus/(deficit)	9.823	1.451	(1.105)
Equity	41.743	25.729	40.331

* Inflated by use of CPB Pharmaceutical Discretionary Fund ($9.78 million).

Independent Crown entities

Health and Disability Commissioner

The Health and Disability Commissioner ensures that the rights of consumers are upheld and encourages health or disability service providers to improve their performance. This includes making sure that consumer complaints are resolved in a fair, timely and effective way. The Commissioner also funds a national advocacy service to help consumers with complaints. A new Commissioner, Morag McDowell, took office on 7 September 2020, replacing Anthony Hill.

As of 1 July 2012, the Commissioner assumed the monitoring and advocacy functions previously delivered by the Mental Health Commission, which was disestablished. A Mental Health Commissioner position, reporting to the Health and Disability Commissioner, was established to oversee the performance of these new functions.

The current Mental Health Commissioner role and associated functions will transfer to the permanent Mental Health and Wellbeing Commission once it is operational. In the meantime, the Initial Mental Health and Wellbeing Commission is carrying out some of the permanent Commission's functions (refer to Ministerial Advisory Committees).

Table 7: Health and Disability Commissioner financial summary

Measure	Actual ($m)* 2018/19	Forecast ($m)* 2019/20	Budget ($m) 2020/21
Income	13.650	13.534	17.975
Expenditure	13.351	13.895	17.962
Surplus/(deficit)	(0.299)	(0.361)	0.013
Equity	1.623	1.361	0.874

Mental Health and Wellbeing Commission

The new Mental Health and Wellbeing Commission (the Commission) being established as part of the response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* will be operational from 9 February 2021 or earlier.

The Commission will contribute to better and equitable mental health and wellbeing outcomes for people in New Zealand. It will monitor and report on the mental health and wellbeing of people in New Zealand, including mental health services; and advocate for the collective interests of service users and populations at greater risk of poor mental health and wellbeing outcomes.

Table 8: Mental Health and Wellbeing Commission financial summary

Measure	Actual ($m)* 2018/19	Forecast ($m)* 2019/20	Budget ($m) 2020/21
Income	N/A	N/A	6.227
Expenditure	N/A	N/A	6,037
Surplus/(deficit)	N/A	N/A	190
Equity	N/A	N/A	190

Note: The Commission is in the process of being established with an effective start date of 9 February 2021. Funding has been allowed for three stages during the 2020/21 financial year (initial Commission $1.401m, establishment $2.701m and the start of the permanent Commission $2.125m).

Departmental agencies

Te Aho o Te Kahu

Te Aho o Te Kahu, the Cancer Control Agency, is a newly established independent departmental agency. It is hosted by the Ministry of Health but reports directly to the Minister of Health. These new arrangements recognise the impact that cancer has on the lives of New Zealanders and provide a sharp focus on this important health issue. Its permanent Chief Executive, Professor Diana Sarfati, was announced on 20 May 2020.

The purpose of the Agency is to provide strong central leadership and oversight of cancer control. It is equity-led, knowledge-driven, person- and whānau-centred and outcomes-focused, taking a whole-of-system focus on preventing and managing cancer. The Agency's vision is:

- fewer cancers
- better survival
- equity for all.

Delivering the required actions identified in the *New Zealand Cancer Action Plan 2019–2029*, Te Aho o Te Kahu provides national leadership with a programme of work that sets the direction for change and delivers improved outcomes for New Zealanders.

District health boards

There are currently 20 DHBs in New Zealand. DHBs implement the health policies of the Government and provide or fund the provision of health services in their districts. DHBs fund PHOs to provide essential primary health care services to their populations. They own and fund public hospitals.

The New Zealand Public Health and Disability Act 2000 establishes DHBs and sets out their objectives, which include:

- improving, promoting and protecting the health of people and communities
- promoting the integration of health services, especially primary and secondary care services
- seeking the optimum arrangement for the most effective and efficient delivery of health services to meet local, regional and national needs
- promoting effective care or support for those in need of personal health services or disability support.

Other DHB objectives include:

- promoting the inclusion and participation in society, and the independence, of people with disabilities
- reducing – with a view to eliminating – health disparities by improving health outcomes for Māori and other population groups.

DHBs are also expected to show a sense of social responsibility, to foster community participation in health improvement and to uphold the ethical and quality standards commonly expected of providers of services and public sector organisations.

DHBs can plan and deliver services regionally, as well as in their own individual districts. To do this, DHBs are generally grouped into four regions. The DHBs of each region work together to find new and better ways of organising, funding, delivering and improving health services to the people in their wider community. The Minister approves agreed regional actions as part of a Regional Services Plan.

The four regions are:

- **Northern** – Northland, Waitematā, Auckland and Counties Manukau DHBs
- **Midland** – Waikato, Lakes, Bay of Plenty, Tairāwhiti and Taranaki DHBs
- **Central** – Hawke's Bay, Whanganui, MidCentral, Hutt Valley, Capital & Coast and Wairarapa DHBs
- **South Island** – Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern DHBs.

Subsets of some regions have an enhanced working relationship, sharing key personnel, developing jointly delivered services and sharing back-office functions like planning and funding, communications and human resources.

Figure 2: District Health Board boundaries

Table 9: DHB office holders, chief executives, populations and 2020/21 funding

DHB	Chair	Deputy chair	Chief executive	Crown Monitor	Population	2020/21 funding $ millions
Northland	Harry Burkhardt	Ngaire Rae	Dr Nick Chamberlain		193,170	$701.7
Waitematā	Professor Judy McGregor	Kylie Clegg	Dr Dale Bramley		628,770	$1,727.6
Auckland	Pat Snedden	William (Tama) Davis	Ailsa Claire		493,990	$1,489.2
Counties Manukau	Vui Mark Gosche	Tipa Mahuta	Fepulea'i Margie Apa	Ken Whelan	578,650	$1,646.8
Waikato	Dame Karen Poutasi, DNZM (Commissioner)	Dr Andrew Connolly, Chad Paraone, Emeritus Professor Hon Margaret Wilson, DCNZM (Deputy Commissioners)	Kevin Snee	Ken Whelan	435,690	$1,402.5
Lakes	Dr Jim Mather	Dr Johan Morreau	Nick Saville-Wood		116,370	$381.0
Bay of Plenty	Sharon Shea (acting)	Sharon Shea	Peter Chandler		259,090	$850.6
Tairāwhiti	Kim Ngarimu	Vacant	Jim Green		49,755	$190.7
Taranaki	Cassandra Crowley	Bridget Sullivan	Rosemary Clements		124,380	$400.0
Hawke's Bay	Shayne Walker	Evan Davies	Keriana Brooking		176,110	$584.0
Whanganui	Ken Whelan	Annette Main	Russell Simpson		68,395	$261.1
MidCentral	Brendan Duffy	Oriana PaSweetewai	Kathryn Cook		186,190	$602.1
Hutt Valley	David Smol	Wayne Guppy	Fionnagh Dougan		156,790	$455.6
Capital & Coast	David Smol	Vacant	Fionnagh Dougan		320,640	$874.6
Wairarapa	Sir Paul Collins, KNZM	Tony Becker	Dale Oliff		48,480	$166.7
Nelson Marlborough	Jenny Black	Craig Dennis	Dr Peter Bramley		159,360	$517.0
West Coast	Hon Rick Barker	Tony Kokshoorn	Dr Andrew Brant (Acting)		32,550	$149.5
Canterbury	Sir John Hansen, KNZM	Gabrielle Huria	Dr Andrew Brant (Acting)	Dr Lester Levy	578,290	$1,628.5
South Canterbury	Ron Luxton	Phil Hope	Nigel Trainor		61,955	$205.0
Southern	Dave Cull	Dr David Perez	Chris Fleming	Roger Jarrold Andrew Connolly	344,900	$1,027.7

Shared services agencies and subsidiaries

Shared services agencies allow DHBs to pool their resources to better deliver common support services. These include:

- HealthAlliance and Northern Regional Alliance (Northern region)
- HealthShare (Midland region)
- Technical Advisory Services (Central region)
- South Island Alliance (South Island region).

Services vary from agency to agency but include health service and funding planning, a range of information and analytical services and provider audit functions. In addition, these agencies provide a platform for further collaborative planning between DHBs.

DHB Shared Services, a division of Technical Advisory Services, directs national collaboration on matters of shared interest. In July 2015, NZ Health Partnerships, a subsidiary of all 20 DHBs, was established to reduce DHBs' costs through the efficient and effective delivery of administrative, support and procurement services.

In addition to the four shared services companies outlined above, DHBs hold shares in a range of other subsidiary companies. These companies provide a variety of specialist services, including laboratory, radiology, disability support and laundry services, and are classified as Crown entity subsidiaries under the Crown Entities Act 2004.

Board appointments

Each DHB board consists of up to 11 members. Seven are elected members and the Minister can appoint up to four members to ensure the board covers a range of perspectives, skills and knowledge. The Minister also appoints each board's chair and deputy chair from among the elected and appointed members. Should a vacancy arise, regardless of whether it is an elected or appointed position, the Minister can fill that vacancy at any time.

Members typically hold office for a three-year term. Appointed members can be reappointed at the end of their term, up to a maximum of nine consecutive years. Elected members can be re-elected indefinitely.

DHB Crown monitors and commissioners

Section 30 of the New Zealand Public Health and Disability Act 2000 (the Act) establishes that the Minister may appoint one or more Crown monitors for the purpose of assisting in improving the performance of a DHB. Crown monitors observe the decision-making processes and the decisions of the board; assist the board in understanding the policies and wishes of the Government; and advise the Minister on any matters relating to the DHB, the board, or its performance.

Section 31 of the Act establishes that where the Minister of Health is seriously dissatisfied with the performance of a board, the Minister may dismiss all members and replace the board with a commissioner, who may appoint up to three deputy commissioners. A commissioner and any deputy commissioners hold office only until the persons elected at the next election of board members take office.

DHB board induction, support and development

Incoming board chairs have a two-day induction programme where they get together and meet joint Ministers, heads of key government departments and experienced chairs.

This is followed by regional board induction days that include Iwi partnership board members. Programming includes addresses by the Minister of Health, Director-General of Health (Director-General), Deputy Director-General of Māori Health and other key sector officials.

An ongoing governance support and development programme provides tools and support for skills assessment and development.

Accountability

As Crown agents, DHBs are accountable to the Government through the Minister. The accountability documents that guide DHBs' planning and performance can be broadly split into three groups: government expectations and planning and accountability documents.

Government expectations

The Minister provides an annual Letter of Expectations to all DHBs and their subsidiaries, which is largely the same. This letter sets out the strategic priorities of the government for the health and disability system. DHBs use this as a focus when they produce their Annual Plan, Regional Service Plan, Statement of Intent and Statement of Performance Expectations.

As with other Crown entities, DHBs are also guided by the Enduring Letter of Expectations which is periodically issued by the Minister of State Services and the Minister of Finance.

Planning and accountability documents

Two documents set out the short-term course DHBs intend to follow to best meet the health needs of their populations.

- **Annual Plan:** This plan sets out how the DHB delivers health services locally to meet Government priorities, with a focus on health equity, and how this can be provided in a financially responsible manner and in line with the DHB's role and functions. Generally DHBs receive planning guidance in December alongside the Minister's Letter of Expectations and provide draft plans for Ministry review in March. Updates often follow May Budget announcements. Plans are progressively finalised and provided to the Minister of Health (and for some, the Minister of Finance) for approval once expectations set out in the guidance have been met.
- **Regional Service Plan:** This plan identifies goals for a region and sets out how these goals will be achieved. The Minister approves the Regional Service Plan and regions regularly report on their progress.

Several documents allow Parliament and the public to measure the performance of DHBs and to hold them accountable.

- **Statement of Intent:** Each DHB must publish a Statement of Intent at least once every three years, setting out the high-level objectives and strategic focus for the next four financial years. The DHB board prepares the Statement of Intent with comment from the Minister. Once the board signs it off, the Minister tables the Statement of Intent in Parliament.
- **Statement of Performance Expectations**: As a component of the Annual Plan, DHBs include a Statement of Performance Expectations containing the forecast financial statements for the current year. The Statement of Performance Expectations can be extracted from the Annual Plan for tabling in Parliament. The DHB board prepares the Statement of Performance Expectations with comment from the Minister. Once the board signs it off, the Minister tables the Statement of Performance Expectations in Parliament.
- **Crown Funding Agreement**: Crown Funding Agreements are made between DHBs and the Minister. These set out the public funding the DHB will receive in return for providing services to its resident population. These agreements can also set out accountability requirements.
- **Operational Policy Framework**: The Operational Policy Framework is a set of business rules, policies and guideline principles that outline the operating functions of DHBs. The Operational Policy Framework is one of the schedules of the Crown Funding Agreement and is updated annually.
- **Service Coverage Schedule**: The Service Coverage Schedule sets out the national minimums for the range and nature of health services to be funded by DHBs. The Service Coverage Schedule is another schedule of the Crown Funding Agreement and is updated annually.
- **Annual Report**: DHBs must report on their performance for the year against the measures set out in their Statement of Performance Expectations and their current Statement of Intent, in accordance with the Crown Entities Act 2004. Annual Reports must be signed off by two board members and provided to the Minister within 15 working days of the DHB receiving the audit report.

Performance

Health System Indicators

In December 2019, Cabinet agreed to the Ministry working with the Health Quality & Safety Commission to create a new measurement framework to publicly report health system performance. The new framework, known as the Health System Indicators, recognises that 20 DHBs around the country have different and unique health needs and challenges. It uses 10 high-level indicators to show national and DHB progress (by ethnicity) with an emphasis on improving equity and health outcomes for Māori and other population groups currently experiencing poorer health outcomes.

The Ministry has worked with the Health Quality & Safety Commission to develop the high-level indicators, but must engage with the health and disability sector to finalise the high-level indicators and implement the framework effectively. DHBs will identify local initiatives that can improve results against the indicators.

System Level Measures

System Level Measures, which were co-designed with the sector and implemented from 1 July 2016, provide a framework for continuous quality improvement and system integration. System Level Measures focus on children, youth and vulnerable populations and enable a whole-of-system approach to improve population health outcomes, reduce health inequities and provide best value for public health system resources. The successful implementation of System Level Measures requires a collaborative way of working, a functional alliance and high-trust relationships among the operational and clinical leaders of the health system.

DHBs, on behalf of their alliances, develop and implement an annual System Level Measures Improvement Plan that includes improvement on the six high-level measures, local improvement actions and local measures to track local progress. The Ministry approves the System Level Measures Improvement Plan.

Performance reporting

In addition to reporting performance in accountability documents, DHBs report their progress towards achieving financial and non-financial performance expectations throughout the year.

The set of regular DHB performance reports includes:

- **Planned Care dashboard** – monthly Planned Care dashboards provide summary information on DHB performance against Planned Care expectations
- **performance heatmap** – quarterly performance heatmaps provide summary information on DHB performance against the planning priority areas included in DHB annual plans and regional service plans
- **balanced scorecard** – a four-quadrant scorecard covering DHB financial performance, service performance, workforce and quality and safety on a quarterly basis, intended to support and inform performance monitoring conversations with DHB stakeholders
- **year-to-date sector financial reporting** – produced monthly, highlighting where the sector, or an individual DHB, reports a significant variance against their Annual Plan financial budgets. Provides information on sector-wide issues with financial implications
- other performance reporting:
  - **Health Infrastructure Package** summary and dashboard (produced monthly)
  - **Health Capital Envelope** summary, update and dashboard (produced quarterly).

Focus on financial sustainability

DHB performance in financial sustainability and some service areas must improve to support better and more equitable health outcomes for the New Zealand population.

The Ministry's DHB Performance, Support and Infrastructure directorate focuses on lifting DHB performance. It delivers the DHB Performance Programme to strengthen the foundations of DHB performance, including:

- the way we appoint, induct and develop our leaders
- the way we lead system and service planning
- the way we support innovation and improvement
- how we measure and monitor performance
- how we engage with the sector
- how we leverage performance through accountability frameworks.

Budget 2019 made dedicated funding available for initiatives to improve DHB sustainability.

Alliances

Alliances are trust-based local partnerships between health providers, funders and community groups to plan and deliver patient-centred health care in response to local population health needs. Alliances provide a forum for joint service development that reflects shared responsibility for a whole-of-system approach to performance and service provision. Effective alliances depend on strong, high-trust, sustainable relationships at the local level, include community, whānau and iwi perspectives and a continuous improvement approach. All DHBs must form an alliance with the PHOs providing primary care services in their district.

While initially only including DHBs and PHOs, alliance memberships have broadened over time (eg, lead maternity carers, providers of ambulance services, Well Child Tamariki Ora services and youth health services) to successfully implement the System Level Measures programme. The form and function of alliances vary across the country.

Health infrastructure and capital investment

There are 88 health capital projects moving through the health capital process and overseen or led by the Ministry's Health Infrastructure Unit (HIU). There are two funding pools:

- Health Capital Envelope – approximately $4.7 billion (48 projects)
- Health Infrastructure Package announced in January 2020 – $300 million (40 projects, including a place holder for Canterbury DHB).

The HIU was established in November 2019 to provide stronger oversight, assurance and standardised project delivery across a national portfolio of DHB-owned and -operated infrastructure.

The core functions of the HIU will address:

- governance and engagement
- service planning
- asset management
- investment strategy
- monitoring and assurance
- programme management and delivery.

Following the completion of *The National Asset Management Programme for district health boards: Report 1: The current-state assessment* (published June 2020), the HIU is now progressing a longer term infrastructure strategy.

DHB-specific directions

Under the New Zealand Public Health and Disability Act 2000, the Minister can give DHBs specific directions. These are in addition to the policy direction and whole-of-government direction provisions in the Crown Entities Act 2004. For example, the Minister can:

- give DHBs directions that specify the persons who are eligible to receive services funded under the Act (ie, Health and Disability Services Eligibility Direction 2011)
- require DHBs to provide or arrange for the provision of certain services
- state how administrative, support and procurement services within the public health and disability sector should be obtained
- direct DHBs to comply with stated requirements to support government policy on improving the effectiveness and efficiency of the public health and disability sector.

Funding and services

DHBs exist within a funding environment where:

- there is a mix of funding models (ie, capitation, fee-for-service, pay-for-performance and individualised funding) and a range of financial and non-financial incentives – the Ministry also contracts directly with providers of some services, such as disability support, national screening services and some mental health and addiction and maternity services
- a population-based funding formula determines the share of funding to be allocated to each DHB, based on the population living in the district – the formula includes adjustors for population age, sex, relative measures of deprivation status and ethnicity
- they are responsible for making decisions on the mix, level and quality of health and disability services within the parameters of national strategies and nationwide minimum service coverage and safety standards
- the Ministry, as the Minister's agent, defines nationwide service coverage, safety standards and the operating environment – the Minister enters into funding agreements with DHBs and may exercise reserve powers in the case of repeated performance failure (ie, dismissing the DHB board or appointing a Crown monitor).

DHB funding is distributed using the population-based funding formula, which allocates funding based on the size and composition of each DHB's population. This means the share of funding each DHB receives is largely determined by whether (and by how much) its population is growing or shrinking relative to others. Statistics New Zealand provides updated DHB populations annually for use in setting DHB funding shares.

In general, DHBs have flexibility to reflect the needs of their populations in the allocation of funding to specific services and in service volumes. However, DHBs have ring-fenced spending targets for mental health and addiction services. This means that although a DHB has discretion over where it allocates funding and can increase its allocation to mental health and addiction, it cannot spend less than the previous year on mental health and addiction.

The Service Coverage Schedule (a schedule to the Crown Funding Agreement) outlines the national minimum range and standard of publicly funded health and disability services and DHBs must ensure their populations have access to all these services. DHBs may provide the services directly or contract with third parties. A DHB may also purchase certain services for their population from another DHB, using a system known as 'inter-district flows'. Where another DHB provides these services, DHBs may use a nationally agreed price or make local arrangements between themselves. A nationwide service framework ensures an appropriate degree of national consistency as directed by the agreed policy settings for specific services.

DHBs pay an additional lump sum to tertiary hospitals to compensate them for the higher costs of maintaining specialist tertiary capability and access. The national prices for inter-district flows and the tertiary adjuster are calculated annually in a joint project between the Ministry and DHBs.

Employment relations

DHB chief executives have the authority to enter into collective or individual employment agreements covering DHB employees. Chief executives' decisions on pay-setting aim to balance labour market drivers (including recruitment and retention) and revenue/funding constraints.

Collective bargaining is the primary means of setting pay and conditions in DHBs. Thirteen national or near-national multi-employer collective agreements cover approximately 65 percent of all DHB employees, while seven regional multi-employer collective agreements cover a further 20 percent. The balance of DHB employees is covered by local collective or individual employment agreements. In addition, there are three collective agreements with the New Zealand Blood Service.

Union density (ie, membership as a proportion of the workforce) is very high in DHBs, at around 70 percent. The unions representing DHB employees include a mix of health sector-specific (typically occupational) unions and general unions. There is some overlapping coverage where two or more unions separately represent the same occupational group.

Role of the Ministry in employment relations

Under the New Zealand Public Health and Disability Act 2000, DHB chief executives must consult with the Director-General before finalising the terms and conditions of a collective agreement. Specific Ministry guidelines, the Operational Policy Framework and the Government Expectations on Employment Relations in the State Sector explain these obligations further.

The Ministry's key roles in health sector employment relations activity are to:

- monitor local, regional and national bargaining
- liaise with and provide information, advice and feedback to the Minister and the Minister of State Services, other government agencies and DHBs
- advise and report to Cabinet, if required.

Health Sector Relationship Agreement

A tripartite Health Sector Relationship Agreement between the Minister and the Ministry, the DHBs and the Combined Trade Unions and their major health affiliates (ie, the New Zealand Nurses Organisation, Association of Salaried Medical Specialists, Public Service Association and Service and Food Workers' Union) was signed in 2008. The Agreement reflects a commitment to constructive engagement and provides a framework and work programme that aims to assist in improving productivity, efficiency and effectiveness in health service delivery, while acknowledging resource constraints.

About the Ministry of Health

Section 2 of the Health Act 1956 specifies that the Chief Executive of the Ministry of Health is the Director-General of Health. In addition to their Chief Executive responsibilities, the Director-General is the government's principal advisor on health matters and has a range of specific policy and regulatory responsibilities that they discharge on behalf of the Crown.

The role of Director-General of Health

The statutory office of Director-General[1] involves a range of dedicated responsibilities. The statutory functions of the Director-General can be summarised as:

> The Director-General is the chief executive of the Ministry. In addition to responsibilities under the Public Service Act 2020, the Director-General has a number of other statutory powers and responsibilities under various pieces of health legislation. These include:
>
> - powers relating to the appointment and direction of statutory public health officers, oversight of the public health functions of local government and authorisation of the use of special powers for infectious disease control under the Health Act 1956
> - powers to certify providers under the Health and Disability Services (Safety) Act 2001
> - powers to issue guidelines under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and other Acts
> - powers under the Epidemic Preparedness Act and various COVID-19 Orders.

The Ministry of Health administers 29 Acts plus a host of supporting regulations, orders, notices and assorted statutory instruments. A full list of legislation administered by the Ministry can be found at Appendix 1. Many of those include statutory responsibilities of the Director-General, which may only be exercised by them or their delegates. Responsibilities include, but are not limited to, the following.

[1] Section 2 Health Act 1956; Section 5 New Zealand Public Health and Disability Act 2000.

- **Appointments:** Appointment of statutory offices including Director of Public Health, Medical Officers of Health and officers under the Medicines Act 1981.
- **Administration:** Statutory responsibilities to provide administrative support to specified statutory committees (such as committees established under the Human Assisted Reproductive Technology Act 2004).
- **Regulation:** Lead regulatory activities such as certification of health and disability service providers, issuing of pharmacy licences and licences under the Radiation Safety Act 2016, approval of new medicines and psychoactive substances. The Director-General is the Psychoactive Substances Regulatory Authority under the Psychoactive Substances Act 2013. This role is currently delegated to the Group Manager, Medsafe, and the Manager, Psychoactive Substances, Medsafe. The Ministry authorises import, supply or use of high-power laser pointers, a range of approvals and authorisations under the Burial and Cremation Act 1964 and designation of points of entry under the International Health Regulations (2009).
- **Enforcement:** Investigation and referral of cases for prosecution of legislation administered by the Ministry (particularly relating to smoke-free legislation, unregistered health practitioners and medicines, solaria operators offering services to people under 18 years of age), plus fraud relating to the Ministry's sector claims processes.
- **Registry maintenance:** Ensuring provision of registries such as the Cancer Register and National Cervical Screening Programme Register.
- **Public health and protection:** Oversight of activity under the Health Act 1956 and Epidemic Preparedness Act 2006, issue of notices under the Victims' Rights Act 2002, Burial and Cremation Act 1964, Biosecurity Act 1993 and Hazardous Substances and New Organisms Act 1996
- **Monitoring:** Ability to call for reports about activities of officers under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.
- **Standards and guidelines**: Ability to issue guidelines and standards of care and treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

In discharging these functions, the Director-General acts as an independent statutory officer. While the Director-General may take advice from others, the statutory requirement is to exercise their decision-making authority independently and not act under direction from other persons. The Director-General is also accountable for the exercise under delegation of any Director-General powers by their staff or any other person acting under their delegated authority.

The role of Chief Executive of the Ministry of Health

The Chief Executive is responsible to the appropriate Minister for:

- carrying out the functions and duties of the department (including those imposed by Act or by the policies of the Government)
- advising the appropriate Minister and other Ministers of the Crown
- the general conduct of the department
- the efficient, effective and economical management of the activities of the department.

Function	Description	Comment
Advice	Provision of departmental advice	Responsibility and accountability for departmental advice provided to the government
Employment	Human resources responsibilities	Responsible for the appointment, and removal, of departmental employees, including acting, temporary or casual employees (section 66 Public Service Act 2020(SSA)) Chief Executives must act independently in the appointment, promotion and disciplining of employees (section 54 PSA) Responsibility for workplace safety under the Health and Safety at Work Act 2015 Human resources, finance and statutory delegations are through the Chief Executive
Finance	Financial responsibilities, including responsibilities under the Public Finance Act 1989	Responsible for financial management and financial performance of the department (section 34 Public Finance Act 1989 (PFA)) Comply with lawful financial actions required by the Minister or responsible Minister (section 34 PFA) Must ensure the department complies with the reporting requirements imposed by both the PFA and any other legislation (section 35 PFA)
Funding	Legal authority to enter into contracts and other commercial agreements on behalf of the Ministry	Can delegate powers in accordance with the PSA. Recent amendments to the Act have extended the scope of the delegation power beyond persons in the Public Service to persons outside the Public Service, but only with Ministerial approval and being satisfied that any potential conflicts of interest can be managed (Schedule 6, clause 2 of the PSA)
Coordination	Support joined-up activity between the Ministry, other government departments and other agencies	Obligation of responsiveness on matters relating to the collective interests of government, including social sector and cross-government initiatives Important aspect of the PSAPFA and Crown Entities Act 2004

Function	Description	Comment
Regulatory and statutory functions	Exercise of statutory powers under legislation, including delegated powers from Ministers and independent decision-making functions	Includes both general authority under the PSA and authority under specific legislation (such as the Health Act 1956) Also includes Director-General responsibilities

Directorate	Description
Chief Financial Officer Fergus Welsh	The Chief Financial Officer is Fergus Welsh. The Chief Financial Officer is a key partner to the Director-General and the Executive Leadership Team (ELT) in supporting sound financial management of both the Ministry's Departmental and Non-Departmental Expenditure (DE and NDE), and ensuring the Ministry meets its responsibilities under the PFA.
Corporate Services Celia Wellington (Acting)	The Corporate Services directorate oversees all our enabling corporate functions. It has a kaitiaki role across the Ministry – protecting and looking after our organisation so we have great people, processes and technology. It provides constructive, professional and strategic advice and support to enable good decision-making, underpinned by fit-for-purpose organisational policy.
COVID-19 Health System Response Sue Gordon (Deputy Chief Executive)	The role of the COVID-19 directorate is to provide oversight of all activities contributing to the Ministry's COVID-19 response. The directorate supports a coordinated, national response for the health sector and ensures an evidence-based response. The directorate has operational functions such as PPE, supply chain, managed isolation, contact tracing through the National Contact Tracing Solution and a national testing plan.
Data and Digital Shayne Hunter	The Data and Digital directorate ensures that the Ministry's data collections and digital technology support the health system to deliver better services and health outcomes. The directorate has oversight of current data and digital functions as well as the national collections.
DHB Performance, Support and Infrastructure Robyn Shearer (Acting)	The DHB Performance, Support and Infrastructure directorate maintains a strong working relationship between the Ministry and DHBs, ensuring strategic leadership and support for DHB planning and funding, accountability for DHB operational performance and oversight of DHB infrastructure and capital projects. The directorate also oversees electives (planned care) and national services.
Disability Adri Isbister	The Disability directorate provides oversight of 'end-to-end' activities and functions for the disability community. This includes purchasing disability support services for people with a long-term physical, intellectual and/or sensory impairment that require ongoing government support to enhance their health and wellbeing, as well as advising on disability policy and ensuring disabled people receive the support services they need.

Directorate	Description
Health System Innovation and Improvement Clare Perry (Acting)	The Health System Innovation and Improvement directorate provides strategic leadership and support for the Ministry and wider health sector to improve service quality and outcomes. This includes leadership of research and evidence, primary care and community health services, quality assurance and improvement, regulation of medicines and medical devices (Medsafe), radiation (Office of Radiation Safety), data analytics and support for innovation in the sector.
Health Workforce Anna Clark	The Health Workforce directorate creates and supports a clear strategy and future pathway for the health workforce in New Zealand. This includes developing workforce policy, planning, commissioning training and supporting innovative workforce initiatives across the sector, including with DHBs. The directorate also has oversight of employment and industrial relations matters across the sector.
Mental Health and Addiction Toni Gutschlag (Acting)	The Mental Health and Addiction directorate oversees the 'end-to-end' activities and functions for mental health and addictions services and leads implementation of the response to the Government Inquiry into Mental Health and Addiction. The Suicide Prevention Office, which was established to provide stronger and sustained leadership on action to prevent suicide, also currently sits within the Mental Health and Addiction Directorate. Officially opened in November 2019, it is led by Director Carla na Nagara.
Māori Health John Whaanga	The Māori Health directorate has an explicit focus on the Crown's Treaty obligations to protect and improve Māori health outcomes. It provides strategic advice and guidance on Māori health improvement in a collaborative and integrated manner across the Ministry and the sector.
Office of the Director-General Sarah Turner	The Office of the Director-General is responsible for government services, internal and external communications and global health and supports the Director-General, Ministers and Executive Leadership Team (ELT). The directorate also carries out Crown entity monitoring, enables Ministers to make Crown entity and responsible authority appointments, and is establishing the permanent Mental Health and Wellbeing Commission.
Office of the Chief Clinical Officers Dr Andrew Simpson Margareth Broodkoorn Dr Martin Chadwick	Dr Andrew Simpson (Chief Medical Officer), Margareth Broodkoorn (Chief Nursing Officer) and Dr Martin Chadwick (Chief Allied Health Professions Officer) provide a strategic clinical lens to ensure services are better planned and delivered for the benefit of New Zealanders. This includes identifying and promoting innovations at a national level, providing oversight and direction on clinical and professional issues across the sector and supporting the response to current and future workforce demand.
Population Health and Prevention Deborah Woodley	Population Health and Prevention works across the sector to achieve health equity and protect, promote and improve the health and wellbeing of people, families and communities. The directorate includes our key national public health functions, emergency management, the National Screening Unit and a range of population health programmes such as oral health, child health, Pacific health, tobacco control and immunisation.

Directorate	Description
Public Health and Primary Care Transformation Don Matheson	This newly established role focuses on creating a strong national public health service, a key next step in strengthening our response to COVID-19 and wider public health issues, and supporting the further development of primary care so that it can play a stronger role in the system, as highlighted in the Health and Disability System Review.
System Strategy and Policy Maree Roberts	The System Strategy and Policy directorate is responsible for the Ministry's core strategy and policy functions, providing leadership and guidance on strategic direction and policy development and advice.

Engaging with Ministers

The Director-General and ELT are available to meet with Minister of Health at the Minister's convenience. This will be arranged with the Minister's office as required.

A team of Private Secretaries and administrative staff are seconded from the Ministry to provide support to the Minister of Health and the Minister's office staff. Ministry secondees also support Associate Ministers. The Ministry will work with your office to discuss how we can best support you. We will contact your staff in due course.

Weekly Reports are our main mechanism for highlighting upcoming activities, issues and risks to Ministers. This document has been provided to the Minister's office on Thursday afternoons, but can be adapted to suit the Minister's way of working. Associate Ministers receive their own Weekly Reports tailored to their delegations, but do not receive the Minister's report. The Minister of Health's office receives copies of Associate Ministers' reports. Ministry staff will engage early with the Minister's office to ascertain the Minister's briefing requirements.

Statutory functions and delegations

Some other Ministry roles have statutory functions, as outlined in the table below.

Role	Statutory responsibilities
Chief Advisor Disability and Director, IDCC&R Dr Amanda Smith	The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 provides for the compulsory care and rehabilitation of individuals with intellectual disabilities that have been either found unfit to stand trial on, or convicted of, an imprisonable offence. The Director-General has several statutory responsibilities under the Act, which have been delegated to the Deputy Director-General Disability Adri Isbister and Chief Clinical Advisor Dr Amanda Smith. These include designating compulsory care coordinators, specialist assessors, medical consultants and district inspectors; issuing guidelines for use of seclusion and restraint, cultural assessment and enforced medical treatment; and authorising short-term leave for special care recipients.
Director of Mental Health and Director of Addiction Services Dr John Crawshaw	The Director of Mental Health is responsible for the general administration of the Mental Health (Compulsory Assessment and Treatment) Act 1992, under the direction of the Minister and Director-General. Functions, duties and powers conferred or imposed by the Act include: • powers of inspection and inquiry into operation of mental health services • issuing guidelines on the Act and standards on the care and treatment of patients • specific provisions with respect to special patients (people who have entered the mental health system through the criminal justice system), including the granting of short-term leave • management of special patients. Ministerial decisions are required from time to time to approve special patients' long leave and change of legal status. The Deputy Director of Mental Health is Toni Dal Din. The Deputy Director of Mental Health performs such general official duties as the Director may require. The Director of Addiction Services is responsible for the general administration of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 under the direction of the Minister and the Director-General.
Director of Public Health Dr Caroline McElnay	The Health Act 1956 prescribes the position of Director of Public Health. The Director of Public Health is Dr Caroline McElnay and the Deputy Directors of Public Health are Dr Harriette Carr, Niki Stefanogiannis and Dr Natasha White. The Director of Public Health has the authority to independently advise the Director-General and Minister on any matter relating to public health and provides national public health professional leadership and professional support and oversight for Ministry-employed and DHB-employed Medical Officers of Health. The Deputy Directors of Public Health assist the Director of Public Health in carrying out statutory and non-statutory responsibilities.

Ministry of Health workforce profile

At 30 June 2020, the Ministry had 1,083 full-time equivalents (FTE), or 1,113 individuals, located in six regions around New Zealand. The 12-month rolling average turnover rate for 2019/20 was 13.9 percent, down from 16.5 percent in 2018/19. The majority of Ministry staff are female (68.1 percent); 31.9 percent are male.

Ethnicity in the workplace	Percentage
Asian	13
European	70
New Zealand Māori	6
Middle Eastern/Latin American/African	<1
Other Ethnic Group	2
Pacific Peoples	4
Unknown	4

Locations	30 June 2020
Auckland	47
Hamilton	11
Whanganui	44
Wellington	915
Christchurch	36
Dunedin	60
Total	**1,113**

Other office holders, organisations and networks

Statutory officers

Public health statutory officers are designated by the Director-General under the Health Act 1956. These officers (medical officers of health, health protection officers and other officers) are accountable to, and subject to direction from, the Director-General. This ensures central oversight of regulatory functions. Most of these officers are employed in DHB-based Public Health Units (PHUs).

Directors of Area Mental Health Services and Directors of Area Addiction Services are appointed by the Director-General but employed by and function within DHBs. They handle day-to-day operation of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and Substance Addiction (Compulsory Assessment and Treatment) Act 2017, respectively.

These statutory officers report to the Director of Mental Health and Addiction Services every three months on the exercise of their powers, duties and functions. There are 22 Directors of Area Mental Health Services (including five with responsibility for forensic mental health services) and nine Directors of Area Addiction Services.

The Minister appoints district inspectors under section 94 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and section 90 of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 to monitor compliance with the compulsory assessment and treatment process. District inspectors are lawyers who work to protect the rights of patients, address concerns of families and whānau and investigate alleged breaches of patient rights, as set out in the respective Acts. There are currently 35 district inspectors.

District inspectors are also appointed under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and fulfil a similar purpose for care recipients subject to that Act. The Act details rights and investigative processes.

Under the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Minister of Health appoints Mental Health Review Tribunal (Review Tribunal) members. The Review Tribunal is an independent body which carries out a number of functions, including deciding whether patients are fit to be released from compulsory status and investigating complaints about breaches of patient rights. There are currently three Review Tribunal members (one lawyer, one psychiatrist and one community member) and 14 deputy members (two lawyers, nine psychiatrists and three community members).

The Director-General also appoints statutory officers under a range of other acts, particularly the Smoke-free Environments Act 1990, the Biosecurity Act 1993, the Psychoactive Substances Act 2013 and the Hazardous Substances and New Organisms Act 1996. City and district councils appoint environmental health officers under the Health Act, who assist councils to perform their environmental health functions under the Act.

Primary health organisations

DHBs fund PHOs to provide essential primary health care services to those people who are enrolled with a general practice. There are 30 PHOs (South Canterbury DHB acts as its own) which vary widely in size and structure. All PHOs are not-for-profit organisations.

A PHO provides primary health care services either directly or through its contracted providers, primarily general practices. These services are designed to improve and maintain the health of the enrolled population. PHOs also ensure that services are provided in the community to restore people's health when they are unwell. The aim is to better link GP services with other health and social services to create a seamless continuum of care.

Accident Compensation Corporation

ACC provides no-fault personal injury cover for New Zealand residents and visitors. ACC can provide financial support for medical treatment, rehabilitation, loss of income and other ongoing costs. It is funded via levies on people's incomes, businesses, petrol and vehicle registration and through the Crown's budget collected via taxes. ACC purchases services directly from health and disability providers. When treatment and/or rehabilitation services are covered, health and disability providers are paid directly, with client co-payments also permitted.

National Ambulance Sector Office

The National Ambulance Sector Office (NASO) is jointly funded by the Ministry and ACC and reports to both agencies. The office is situated within the Ministry.

NASO commissions emergency ambulance services so that the most critically unwell New Zealand residents can access high quality clinical care, saving lives and reducing long-term disability.

NASO manages and monitors ambulance service contracts on behalf of its parent agencies to ensure New Zealand's emergency ambulance services (road and air):

- provide high quality, safe clinical outcomes for everyone
- cover all of New Zealand
- are closely integrated with other health and emergency services
- are sustainable over the long term.

NASO provides strategic and operational advice and funds New Zealand's emergency ambulance services. NASO works closely with emergency ambulance providers, the broader health sector and government agencies to achieve these outcomes.

Non-governmental organisations

The Ministry and DHBs provide significant funding – from $2 to $4 billion per year – to NGOs. Many NGOs are not-for-profit and provide services to consumers as well as expertise, intelligence and influence at a community level.

NGOs have a long, well-established record of contributing to health and disability service delivery in New Zealand. NGOs include a wide range of organisations that provide flexible, responsive and innovative frontline service delivery. Diverse services are offered in primary care, mental health, personal health and disability support services, including kaupapa Māori services and Pacific health services.

The Ministry and NGOs have a formal relationship outlined in the Framework for Relations between the Ministry and health and disability NGOs. The Health and Disability NGO Council facilitates this relationship and includes two non-voting Ministry representatives who manage the relationship between the Council and the Ministry.

Public health services

Public health services are delivered by 12 DHB-owned PHUs and a range of NGOs. DHB-based services and NGOs each deliver about half of these services.

PHUs focus on environmental health (including drinking water safety), communicable disease control, tobacco and alcohol control, health promotion programmes, health status assessment and surveillance and public health capacity development. Many of these services include a regulatory component performed by statutory officers appointed under various statutes, principally the Health Act 1956. Responsibility for food safety sits with the Ministry for Primary Industries, although PHUs take the lead in investigating outbreaks of food-borne illness.

PHUs have played a key role in the COVID-19 response, particularly case investigation and contact tracing and management.

Local and regional authorities

Local authorities were traditionally bound to the specific activities prescribed for them through statute. The general empowerment to promote community wellbeing conferred by the Local Government Act 2002 has, however, allowed their role to increasingly encompass proactive initiatives to promote community wellbeing. The nature of these activities varies between regional councils and territorial authorities and depends on council resources and priorities.

Core local government activities that promote public health include a regulatory role as building consent authorities; resource management; the provision of social housing; regulating the sale and supply of alcohol through District Licensing Committees; management of the drinking, waste and storm waters and infrastructure; drainage; sewerage works; recreation facilities and areas; refuse and recycling collection; and civil defence emergency management.

Clinical networks

Clinical networks increase connectivity across the health and disability sector and are a significant feature of our health and disability system. There are several key networks of clinicians working to improve the quality of health services. Clinical networks have been instrumental in achieving gains in the health sector, including the implementation of:

- accelerated chest pain pathways in DHBs, which speed up the diagnostic process for patients with chest pain without compromising safety
- telestroke services, which enable acute stroke patients to be managed more quickly and closer to home.

Clinical network	Description
Adolescent and Young Adult Cancer Network Aotearoa	The Adolescent and Young Adult Cancer Network Aotearoa focuses on improving cancer outcomes for adolescents and young adults. The Clinical Lead for the Adolescent and Young Adult Cancer Network Aotearoa is Heidi Watson. The Network supports all providers of cancer services for adolescents and young adults and has developed relevant standards of care.
Major Trauma National Clinical Network	The Major Trauma National Clinical Network provides clinical leadership and oversight to support a planned and consistent approach for major trauma services across New Zealand. The Network's Clinical Leader is Associate Professor Ian Civil. Its work programme includes the National Major Trauma Registry and the establishment of nationally consistent clinical guidelines and pre-hospital destination policies. The Major Trauma National Clinical Network aims to reduce preventable levels of mortality, complications and lifelong disability amongst people who sustain a major trauma injury. The Network is hosted by ACC.
National Stroke Network	The National Stroke Network's objective is to facilitate equitable access and improve outcomes for stroke survivors and their families and whānau. This includes, through the implementation of best practice as set out in the New Zealand Clinical Guidelines for Stroke Management 2010, and updated guidance provided by the network, and to support the Ministry of Health achieve improved stroke care services in DHBs. The National Stroke Network is chaired by Dr Alan Davis.
New Zealand Cardiac Network	The New Zealand Cardiac Network provides national leadership across the cardiac continuum of care, facilitates and encourages communication between stakeholders, and supports regional networks in achieving their specific goals. The New Zealand Cardiac Network is chaired by Associate Professor Gerry Devlin.
National Cardiac Surgery Clinical Network	The National Cardiac Surgery Clinical Network provides national leadership across cardiac surgery services to increase the volume of cardiac surgery operations, improve the geographical equity of cardiac surgery provision, enhance the effectiveness of clinical prioritisation and reduce the number of patients waiting for surgery. The National Cardiac Surgery Clinical Network is chaired by Mr Harsh Singh.
National Child Cancer Network	The National Child Cancer Network provides advice, recommendations and action plans on specific areas of service delivery (eg, fertility preservation) and shares information, knowledge and best practice across the country. The National Child Cancer Network's Chair is Dr Scott Macfarlane.
National Child and Youth Clinical Network	The National Child and Youth Clinical Network oversees paediatric specialist networks. The Chair of the National Child and Youth Clinical Network is Dr Richard Aickin. The National Child and Youth Clinical Network partners with key stakeholders to strengthen clinical leadership and engagement, support improved local, regional and national service and capacity planning and improve system performance in child and youth health.

Health sector agreements and payments

The total appropriation for the health sector is approximately $22 billion. Of that, approximately $10 billion of DHB, Ministry and provider payments are processed on behalf of the funders by the Ministry of Health. Each year there are 92 million transactions against nearly 70 service lines. The Ministry is coordinating with funders to transform the business processes and underlying technology.

Māori health

The Ministry of Health's new Te Tiriti o Waitangi framework provides a tool for the health and disability system to fulfil its stewardship obligations and special relationship between Māori and the Crown. Te Tiriti o Waitangi not only describes Māori rights and Crown obligations but is also a key improvement tool for achieving health equity and wellbeing for Māori.

He Korowai Oranga

He Korowai Oranga is a high-level strategy that supports the Ministry of Health and district health boards (DHBs) to improve Māori health. Implementing He Korowai Oranga is the responsibility of the entire health and disability sector. It has implications for other sectors as well.

DHBs should consider He Korowai Oranga in their planning and in meeting their statutory objectives and functions for Māori health. He Korowai Oranga assists Māori providers and communities and other providers to plan their own strategic development.

The elements, directions, key threads and pathways of He Korowai Oranga guide the health system to improve Māori health and realise pae ora – healthy futures. The four pathways of the original He Korowai Oranga framework tell us how to implement the strategy. These pathways are:

1. supporting whānau, hapū, iwi and community development
2. supporting Māori participation at all levels of the health and disability sector
3. ensuring effective health service delivery
4. working across sectors.

Whakamaua: Māori Health Action Plan 2020–2025 guides the Ministry, the health and disability system and government to give effect to He Korowai Oranga. It sets out a suite of outcomes, objectives and priority areas for action that will contribute to the achievement of pae ora – healthy futures for Māori.

Whakamaua focuses on four high-level outcomes to realise the vision of pae ora.

1. Iwi, hapū, whānau and Māori communities can exercise their authority to improve their health and wellbeing.
2. The health and disability system is fair and sustainable and delivers more equitable outcomes for Māori.
3. The health and disability system addresses racism and discrimination in all its forms.
4. The inclusion and protection of mātauranga Māori throughout the health and disability system.

Global health

New Zealand has a history of strong support for global health. We have been on the World Health Organization (WHO) Executive Board six times since the 1950s, regularly attend the WHO Western Pacific Regional Committee Meeting and recently became full members of the Pacific Health Ministers Meeting. New Zealand is often invited to lend technical expertise in a range of areas and is seen as a rules-based player.

As a good global citizen, New Zealand is committed to achieving the Sustainable Development Goals by 2030. As stewards of the health system, the Ministry leads Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages.

The Ministry has three enduring objectives for global engagement. While priority topics may change over time, the rationale for the Ministry's international engagement remain consistent. They are:

- contribute towards the global and regional health agenda
- learn from the experience of others
- meet international obligations.

International entities

World Health Organization

The WHO is a specialised agency of the United Nations and is the primary global agency for international health activity. It is a forum for debate on issues such as the performance of health systems, improved surveillance methods, reporting and control of communicable diseases and ways to reduce non-communicable diseases. New Zealand is one of 194 member states of the WHO.

New Zealand has the opportunity to contribute and influence its work programme at core WHO Member State meetings. The World Health Assembly is the annual overarching decision making body of the WHO. Under normal circumstances, delegations from up to 194 member states attend each May in Geneva, Switzerland.

The Minister of Health typically represents New Zealand at the World Health Assembly, while officials typically represent New Zealand at WHO Executive Board meetings (January and May) and at the Regional Committee for the Western Pacific (October).

The Ministry's Global Health team works closely with the Ministry of Foreign Affairs and Trade Permanent Representative to Geneva and the United Nations, Human Rights and Commonwealth Division on the WHO's day-to-day operations and work programmes. This engagement has increased significantly since the emergence of COVID-19.

At present, in line with the May 2020 World Health Assembly Resolution 73.1, there is a single, phased process of evaluating the global response to COVID-19. This includes:

- Independent Panel for Pandemic Preparedness and Response (IPPR) (Rt Hon Helen Clark is co-chair)
- Review Committee on the functioning of the IHR (2005) during the COVID-19 pandemic (IHR RC)
- Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (IOAC)
- investigation into the zoonotic source.

These processes will report regularly to scheduled and ad-hoc WHO Member State meetings. The Ministry's Global Health team, alongside key stakeholders (Ministry of Foreign Affairs and Trade and Ministry for Primary Industries), is leading New Zealand's response to the global review of COVID-19.

Asia-Pacific Economic Cooperation (APEC)

In August 2020, Cabinet decided that New Zealand's APEC 2021 host year will be entirely virtual, using digital platforms, due to the uncertainties introduced by COVID-19.

APEC is an inter-governmental forum for 21 member economies in the Pacific Rim that promotes free trade throughout the Asia-Pacific region. Members are referred to as 'economies' because not all members are states and because the APEC process mainly concerns trade and economic issues.

The APEC Health Working Group is a forum dedicated to demonstrating the value of health to economic growth and building awareness of the return on investment on health innovation. It arose out of the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003.

The Ministry has not engaged with APEC recently. However, as APEC host in 2021, the Ministry is assuming an active member role in the APEC Health Working Group.

Other international organisations

New Zealand also maintains links with the Organisation for Economic Co-operation and Development (OECD), the Commonwealth Fund (an NGO based in New York City, USA that conducts comparative health policy research), other regional and global organisations and leading international technical experts and non-governmental agencies on public health issues.

Ministers and officials are invited to attend a range of health forums and technical advisory groups across international organisations.

The Commonwealth

Regular Commonwealth Health Ministers' meetings occur prior to the World Health Assembly each year. New Zealand maintains links with Health Ministers and authorities elsewhere in the Commonwealth.

Australia

The New Zealand Director-General of Health participates in the Australian Health Ministers' Advisory Committee. There are expected to be some changes to this group, and others such as the Australian Health Protection Principal Committee (which played a key role in COVID-19). At this stage, we expect New Zealand's participation will continue at officials' level.

Pacific links

Pacific Health Ministers meet every two years to consider regional initiatives and collaborate on existing or emerging health issues. The biennial meeting is hosted by the WHO and the Pacific Community. New Zealand and Australia also participate. As Associate Minister of Health, Hon Jenny Salesa attended meetings and the Ministry recommends a continuation of Ministerial attendance at these meetings.

In addition to these ministerial meetings, Ministry officials have frequent contact with their Pacific counterparts, often comprising requests for technical advice.

Pacific countries, and Polynesia in particular, have looked increasingly to New Zealand for advice and support around COVID-19. The Ministry's focus has provided direct technical support to Polynesia, providing an opportunity for the Ministry to develop a close working relationship with counterparts in Polynesia. This has included regular fortnightly meetings between Ministry and Polynesian health officials.

Health Corridors

Health Corridors is a six-year programme (2019/20–2024/25) funded by the Ministry of Foreign Affairs and Trade and managed by the Ministry of Health. It aims to improve health outcomes in six participating countries (Cook Islands, Niue, Samoa, Tokelau, Tonga and Tuvalu) by strengthening the existing links with the New Zealand health system.

The programme's five key workstreams have been informed by the WHO health system building blocks and our recent COVID-19 engagement with Polynesia. They are:

1. service delivery
2. workforce development
3. leadership and governance

4. access to essential medicines (total value $8.1 million)
5. pandemic preparedness and response.

Work is currently under way to develop an implementation plan for the Health Corridors programme. While the Ministry will manage Health Corridors, we will continue to work in close partnership with MFAT to implement this programme.

International conventions and agreements

New Zealand is party to two international treaties that specifically relate to health, along with other agreements which have public health implications.

WHO Framework Convention on Tobacco Control

The WHO Framework Convention on Tobacco Control was developed in response to the globalised tobacco epidemic. It is an evidence-based treaty that reaffirms the right of all people to the highest standard of health and has become one of the most rapidly and widely embraced treaties in United Nations history (currently 168 signatories). New Zealand participated in its development, signed it in June 2003 and ratified it in January 2004. The treaty covers such issues as tobacco advertising, price and tax measures and the packaging and labelling of tobacco products.

International Health Regulations

The International Health Regulations 2005 are binding on New Zealand, as they are on most WHO member states. The Regulations focus on early detection and response to public health threats of international concern, including biological (communicable diseases, pests and vectors), radiation and chemical hazards. They are a key mechanism to prevent and control the spread of disease and other public health risks between countries and provide the primary international legal framework for both the WHO and its member states to assess and respond to emerging international threats to public health. The Regulations' adoption by WHO, and implementation by countries like New Zealand, is a critical part of emergency preparedness and routine surveillance and control of international public health risks.

Under the Regulations, all countries need a national focal point to act as a whole-of-government communication channel with the WHO and oversee national preparedness for a wide range of public health threats. In New Zealand, the Public Health Group and the Office of the Director of Public Health perform this role.

Joint External Evaluation and National Health Security Action Plan

The International Health Regulations (2005) include requirements for countries to develop and maintain minimum core capacities to respond effectively to disease outbreaks and public health events. The monitoring and evaluation framework includes a joint external evaluation process.

Others

Several other international documents are relevant to public health. Some examples are:

- The **Ottawa Charter for Health Promotion** (1986)
- The **Manila Declaration on Health and Environment** (2016)
- The **Paris Agreement** (2018)
- The **Stockholm Convention** (2004)
- The **Basel Convention** (1989).

Appendix 1: Legal and regulatory framework

Legislation the Ministry administers

The Ministry administers a wide range of acts, regulations and other legislative instruments such as Orders in Council. The following briefly describes the principal acts administered by the Ministry.

Burial and Cremation Act 1964	Outlines the law relating to the burial and cremation of the dead.
Cancer Registry Act 1993	Provides for the compilation of a statistical record of the incidence of cancer in its various forms, as a basis for better direction of programmes for research and prevention.
Compensation for Live Organ Donors Act 2016	Provides for compensation for lost income to be paid to live donors of organs.
COVID-19 Public Health Response Act 2020	Supports measures taken to respond to COVID-19.
End of Life Choice Act 2019	Gives persons who have a terminal illness and who meet certain criteria the option of lawfully requesting medical assistance to end their lives and establishes a process for assisting eligible persons who exercise that option. Commencement is subject to the outcome of the referendum held at the 2020 general election.
Epidemic Preparedness Act 2006	Provides statutory power for government agencies to prevent and respond to the outbreak of epidemics in New Zealand, and to respond to some potential consequences of epidemics (whether occurring in New Zealand or overseas). This Act also aims to ensure that certain activities can continue during an epidemic in New Zealand and enables the relaxation of some statutory requirements that might not be complied with, or complied with fully, during an epidemic.
Health Act 1956	Sets out the roles and responsibilities of individuals to safeguard public health, including the Minister, the Director of Public Health and designated officers for public health. It contains provisions for environmental health, infectious diseases, health emergencies and the National Cervical Screening Programme.

Health and Disability Commissioner Act 1994	Aims to promote and protect the rights of health consumers and disability service consumers to secure fair, simple, speedy and efficient resolution of complaints. It provides for the appointment of a Health and Disability Commissioner to investigate complaints and defines the Commissioner's functions and powers. It also provides for the establishment of a Health and Disability Services Consumer Advocacy Service and for the promulgation of a Code of Health and Disability Services Consumers' Rights.
Health and Disability Services (Safety) Act 2001	Promotes the safe provision of health and disability services to the public and establishes consistent and reasonable standards of service for providers.
Health Benefits (Reciprocity with Australia) Act 1999	Provides for reciprocity with Australia in relation to pharmaceutical, hospital and maternity benefits.
Health Benefits (Reciprocity with the United Kingdom) Act 1982	Provides for reciprocity with the United Kingdom in relation to medical, hospital and related benefits.
Health Practitioners Competence Assurance Act 2003	Aims to ensure health practitioners are competent and fit to practise their professions. It provides for: (a) a consistent accountability regime for all registered health practitioners (b) the determination of the scope of practice within which each health practitioner is competent (c) systems to ensure that no health practitioner practises outside his or her scope of practice (d) power to restrict specified activities to particular classes of health practitioner (e) certain protections for health practitioners who take part in protected quality assurance activities.
Health Research Council Act 1990	Defines the functions and powers of the Health Research Council of New Zealand, a Crown entity responsible for managing government's investment in health research.
Health Sector (Transfers) Act 1993	Governs the sale or transfer of assets, liabilities or functions from DHBs and certain health Crown entities to the Crown or other specified bodies.
Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016	The Act sets out the minimum payment to home and community support workers for travel time and reimbursement of travel costs for travel between clients.
Human Assisted Reproductive Technology Act 2004 (in conjunction with the Ministry of Justice)	Governs assisted reproductive technology, including by: • providing a framework for the regulation and performance of assisted reproductive procedures • prohibiting certain procedures, types of research and transactions • establishing an information-keeping regime for people born from donated embryos or cells to find out about their genetic origins.

Human Tissue Act 2008	Governs the collection and use of human tissue to ensure it is done in an appropriate way, without endangering the health and safety of members of the public, and that it does not involve payment.
Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003	Provides for the compulsory care and rehabilitation of individuals with an intellectual disability who have been charged with, or convicted of, an imprisonable offence.
Medicines Act 1981	Covers the law relating to the manufacture, sale and supply of medicines, medical devices and related products.
Mental Health and Wellbeing Commission Act 2020	Establishes the Mental Health and Wellbeing Commission; to fully come into force on 9 February 2021.
Misuse of Drugs Act 1975	Aims to prevent the misuse of drugs. Includes provisions relating to regulation of medicinal cannabis.
Mental Health (Compulsory Assessment and Treatment) Act 1992	Defines the circumstances and conditions under which people may be subjected to compulsory psychiatric assessment and treatment. It defines and protects the rights of such people, and generally defines the law relating to the assessment and treatment of people suffering from mental disorders.
New Zealand Public Health and Disability Act 2000	Establishes the structure underlying public sector funding and the organisation of health and disability services. It establishes DHBs and certain health Crown entities and sets out the duties and roles of key participants, including the Minister and ministerial advisory committees.
New Zealand Public Health and Disability (Waikato DHB) Elections Act 2019	Cancelled the 2019 Waikato DHB election.
Psychoactive Substances Act 2013	Regulates the importation, manufacture and supply of psychoactive substances in New Zealand to protect the health of, and minimise harm to, individuals who use psychoactive substances.
Radiation Safety Act 2016	Establishes a framework to protect the health and safety of people and protect the environment from the harmful effects of ionising radiation while allowing for the safe and beneficial use of ionising radiation. Enables New Zealand to meet international obligations relating to radiation and nuclear non-proliferation.
Smoke-free Environments Act 1990	Aims to: (a) reduce the exposure of people who do not themselves smoke to any detrimental effect on their health caused by others' smoking (b) regulate the marketing, advertising and promotion of tobacco products, whether directly or through the sponsoring of other products, services or events (c) monitor and regulate the presence of harmful constituents in tobacco products and tobacco smoke.
Substance Addiction (Compulsory Assessment and Treatment) Act 2017	Provides for the care and treatment of people with alcohol and drug addictions.
Support Workers (Pay Equity) Settlement Act 2017	This settlement addresses a historic undervaluing of care and support workers in New Zealand's aged and disability residential care, home and community support and mental health services.

Other regulatory roles and obligations

In addition to administering legislation, key personnel within the Ministry (such as the Directors of Public Health and Mental Health) have specific statutory powers and functions under various pieces of legislation.

The Ministry also has certain statutory roles and relationships defined in other legislation, including:

- Biosecurity Act 1993
- Civil Defence Emergency Management Act 2002
- Contraception, Sterilisation, and Abortion Act 1977
- Criminal Procedure (Mentally Impaired Persons) Act 2003
- Education and Training Act 2020
- Food Act 2014
- Gambling Act 2003
- Hazardous Substances and New Organisms Act 1996
- Litter Act 1979
- Local Government Act 2002
- Maritime Security Act 2004
- Prostitution Reform Act 2003
- Residential Care and Disability Support Services Act 2018
- Sale and Supply of Alcohol Act 2012
- Social Security Act 2018
- Victims' Rights Act 2002
- Waste Minimisation Act 2008.

Appendix 2: Other statutory bodies, committees and office holders

This appendix provides a brief description of the roles and functions of those bodies, committees and individuals appointed by the Minister that have not already been discussed. Some bodies also have members appointed in other ways (eg, through elections), or by virtue of their job. This appendix is ordered alphabetically by statute of establishment.

Health Act 1956

National Kaitiaki Group

The National Kaitiaki Group is established under the Health (Cervical Screening (Kaitiaki)) Regulations 1995. It ensures Māori control and protection of Māori women's cervical screening data. The group:

- considers applications for approval to disclose, use or publish protected information
- responds to the requests for data release as soon as reasonably practicable after receiving the request
- grants approval for such disclosure, use or publication in appropriate cases.

National Cervical Screening Programme review committee

The Minister must establish a review committee at least once every three years, to review the operation of the National Cervical Screening Programme and evaluate the programme's service delivery and outcomes.

Health Practitioners Competence Assurance Act 2003

Responsible authorities

There are currently 17 responsible authorities under the Health Practitioners Competence Assurance Act 2003:

- Chiropractic Board
- Dental Council
- Dietitians Board
- Medical Council of New Zealand
- Medical Radiation Technologists Board
- Medical Sciences Council of New Zealand
- Midwifery Council
- Nursing Council of New Zealand
- Occupational Therapy Board
- Optometrists and Dispensing Opticians Board
- Osteopathic Council
- Paramedic Council
- Pharmacy Council
- Physiotherapy Board
- Podiatrists Board
- Psychologists Board
- Psychotherapists Board.

Responsible authorities describe scopes of practice for their professions (these set the boundaries within which a practitioner can practise), prescribe necessary qualifications, register practitioners and issue practising certificates. They also set standards of clinical and cultural competence and ethical conduct. Responsible authorities can investigate individual practitioners' fitness, competence and conduct.

These authorities are funded by fees charged and a disciplinary levy on their professions and have their own staff and premises (some authorities share offices and certain back-office functions). While the Minister has a power of audit, regulatory authorities have autonomy in making decisions such as setting scopes of practice or fees.

The Minister appoints a mix of health practitioners and laypersons to each board/council. The chair and deputy chair are elected from among each board's/council's members. The Minister can regulate that members of the profession elect a proportion of the health professional members of an authority (as with the Medical Council and the Nursing Council).

Health Practitioners Disciplinary Tribunal

The Health Practitioners Disciplinary Tribunal hears and determines more serious cases against health practitioners. It comprises a chair, deputy chairs and a panel of layperson and health practitioner members (there are approximately 140 Tribunal members in total).

When the Tribunal sits to hear and determine a charge, it comprises five people: the chair or one of the deputy chairs, a layperson appointed from the panel and three health professionals appointed from the panel who are peers of the health practitioner subject of the hearing.

Human Assisted Reproductive Technology Act 2004

Ethics Committee on Assisted Reproductive Technology

The functions of the Ethics Committee on Assisted Reproductive Technology include:

- considering and determining applications for assisted reproductive procedures, extending the storage period of gametes and embryos and human reproductive research
- keeping under review any approvals previously given and monitoring the progress of any assisted reproductive procedures performed or any human reproductive research conducted under current approvals
- any other functions the Minister assigns to it.

Advisory Committee on Assisted Reproductive Technology

The Advisory Committee on Assisted Reproductive Technology has several statutory functions, including:

- issuing guidelines and advice to the Ethics Committee on Assisted Reproductive Technology on assisted reproductive procedures, extending the storage period of gametes and embryos and human reproductive research
- providing the Minister with advice on assisted reproductive procedure and human reproductive research
- any other function the Minister assigns to it.

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

District inspectors

District inspectors appointed under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 monitor, protect and give effect to the rights of people receiving compulsory care and rehabilitation (as set out in the Act) by making regular visits to facilities, investigating alleged breaches of rights or employees' duties and assisting with enquiries by High Court judges.

Medicines Act 1981

Medicines Adverse Reactions Committee

The Medicines Adverse Reactions Committee advises the Minister on the safety of approved medicines. Its functions are to:

- provide expert advice to the Director-General and the Minister in relation to the safety or efficacy of a medicine that is the subject of a notice issued under section 36 of the Medicines Act 1981
- consider information about the safety of medicines (including vaccines) that is referred to the Committee by Medsafe and provide expert advice to the Minister and Medsafe on:
  - the interpretation of the information
  - the significance of the information in relation to the risk/benefit profile of the medicines
  - whether a regulatory intervention under the Medicines Act 1981 is desirable to minimise the risks from use of the medicine.

Medicines Assessment Advisory Committee

The Medicines Assessment Advisory Committee provides advice to the Minister on the benefits and risks of new medicines. Its functions are to:

- consider applications for the Minister's consent or provisional consent to the distribution of a new medicine referred to the Advisory Committee
- report to the Minister with a recommendation on the decision the Minister should make in respect of applications referred to the Advisory Committee
- annually review a sample of reports of the evaluation of applications for the Minister's consent or provisional consent to the distribution of new medicines and provide expert advice to Medsafe and the Minister on the quality of completed risk/benefit assessments.

Medicines Classification Committee

The Medicines Classification Committee makes recommendations on whether medicines should be classified as prescription, restricted or pharmacy-only. This affects the public availability of medicines and how they are funded. The Committee also reports to the Minister more generally on the classification of medicines and their accessibility.

The Committee's membership must include two nominees each from the New Zealand Medical Association, the Pharmaceutical Society of New Zealand and the Ministry (one of whom is required to be the chair).

Medicines Review Committee

The Medicines Review Committee's functions are to:

- inquire into any objections to recommendations regarding applications for ministerial consent to distribute new medicine and to report its findings to the Minister
- hear appeals under section 88 of the Medicines Act 1981, such as:
  - refusals by the Ministry to issue licences to manufacture, pack or sell medicines or operate a pharmacy
  - appeals against refusal by the Director-General of an application for approval to carry out a clinical trial of a medicine
  - appeals against a decision by the Director-General that a medical device may not be sold until the Director-General is satisfied as to its safety.

Mental Health (Compulsory Assessment and Treatment) Act 1992

Mental Health Review Tribunal

The Mental Health (Compulsory Assessment and Treatment) Act 1992 empowers the state to deprive people of their liberty should they be found to be mentally disordered and a danger to themselves or others. The Act provides for a District Court judge to make compulsory treatment orders for comprehensive procedures of review and appeal of decisions about the patient's condition and legal status.

The principal role of the Mental Health Review Tribunal is to consider whether a patient is fit to be released from compulsory status. There is a requirement for every person subject to a compulsory treatment order to have his or her condition reviewed at least every six months. Should a patient disagree with their responsible clinician's decision that they are not fit to be released from compulsory status, the patient may apply to the Tribunal for a review of his or her condition. The patient can appeal a Tribunal decision to the District Court or High Court.

The Mental Health Review Tribunal also:

- investigates complaints about breaches of patient rights (where the complainant is not satisfied with the outcome of their complaint to a district inspector)
- makes recommendations about the status of special patients
- considers the status of restricted patients
- appoints the psychiatrists who give second opinions about patient treatment.

District inspectors for mental health

District inspectors are lawyers appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 to protect the rights of people being assessed or treated under the Act. District inspectors provide an important safeguard for people who have concerns about compulsory care or treatment. They can investigate complaints about treatment under the Act, inspect mental health facilities and make recommendations to Directors of Area Mental Health Services.

Misuse of Drugs Act 1975

Expert Advisory Committee on Drugs

The Expert Advisory Committee on Drugs:

- conducts reviews of psychoactive substances to assess harm to the individual and society
- recommends to the Minister whether and how such substances should be classified as controlled drugs under the Act
- increases public awareness of its work by (for instance) releasing papers, reports and recommendations.

New Zealand Public Health and Disability Act 2000

Health and Disability Ethics Committees

The Health and Disability Ethics Committees are a group of four nationally focused ethics committees (Northern A, Northern B, Central and Southern), established under section 11 of the New Zealand Public Health and Disability Act 2000. They check that health and disability research (such as clinical trials) meets or exceeds ethical standards established by the National Ethics Advisory Committee.

National Ethics Advisory Committee

The National Ethics Advisory Committee is established under section 16 of the New Zealand Public Health and Disability Act. Its purpose is to:

- provide advice to the Minister on ethical issues of national significance in respect of any health and disability matters (including research and health services)
- determine nationally consistent ethical standards across the health and disabilities sector and provide scrutiny for national health research and health services.

Psychoactive Substances Act 2013

Psychoactive Substances Appeals Committee

The Psychoactive Substances Appeals Committee determines appeals against decisions of the Psychoactive Substances Regulatory Authority made by or under the Psychoactive Substances Act 2013.

Psychoactive Substances Expert Advisory Committee

The Psychoactive Substances Expert Advisory Committee evaluates trials and advises the Psychoactive Substances Regulatory Authority on approval for use of psychoactive products.

Radiation Safety Act 2016

Radiation Safety Advisory Council

The members of the Council are Ministerial appointees. The Council advises the Director of Radiation Safety and the Minister on radiation safety and standards and makes recommendations in accordance with section 81 of the Radiation Safety Act.

Substance Addiction (Compulsory Assessment and Treatment) Act 2017

District inspectors

District inspectors are lawyers appointed under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 to protect the rights of people being assessed or treated under the Act. They have a similar role to mental health district inspectors.