

The New Zealand Health and Disability System: Organisations and Responsibilities

Briefing to the Minister of Health

December 2011

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1 Health and Disability System: Overview

Every day, New Zealanders can access a comprehensive range of health and disability services. In the year to 30 June 2011:

- 62,660 people were born
- 29,320 people died
- 65.4 million prescription items were dispensed
- 23.9 million laboratory tests were performed
- there were approximately 13.8 million general practitioner visits
- there were approximately 996,000 emergency department attendances
- there were nearly 1 million in/day patient hospital discharges
- there were 217,000 elective in/day patient admissions, of which 154,000 were for surgical elective services.

Services are delivered by a complex network of organisations and people (see Figure 1). Each has their role in working with others across the system to achieve better health and independence for New Zealanders.

This report contains an overview of the health and disability system as it exists in November 2011. It describes the major organisations and structures in the system, the key players, and their roles, functions, and responsibilities. The primary focus is on those organisations which fall within the Vote Health purview.

A complex system, working together

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 supported by the Ministry of Health (the Ministry) and its business units, and advised by the Ministry, the National Health Board, Health Workforce New Zealand, the National Health Committee, and other ministerial advisory committees.

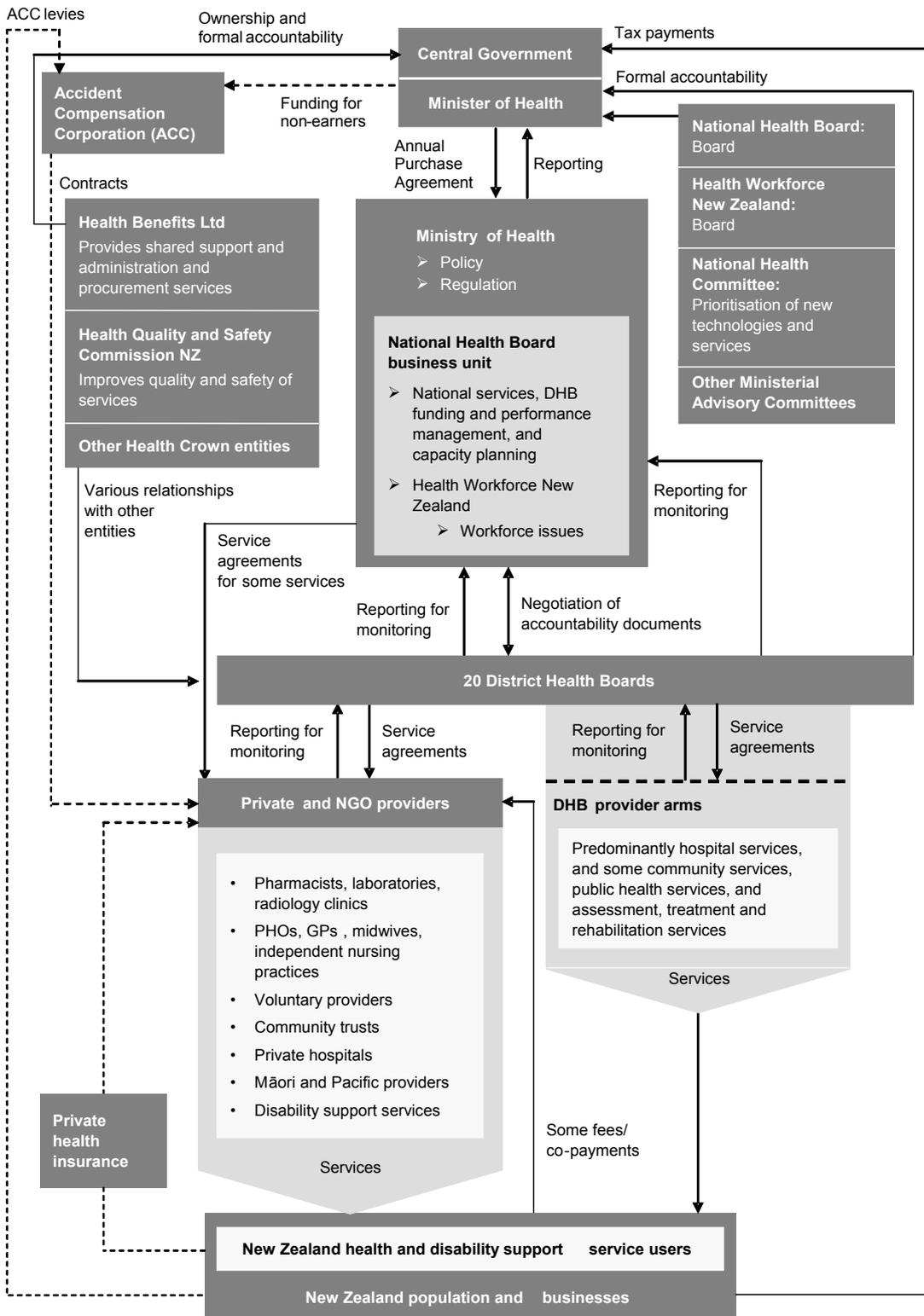
Most of the day-to-day business of the system, and around three-quarters of the funding, is administered by district health boards (DHBs). DHBs plan, manage, provide and purchase health services for the population of their district, to ensure services are arranged effectively and efficiently for all of New Zealand. This includes funding for primary care, hospital services, public health services, aged care services, and services provided by other non-government health providers including Māori and Pacific providers.

The Ministry has a range of roles in the system in addition to being the principal advisor to the Minister. It currently retains centralised funding for a range of important national services, including disability support and public health services.

The entire system stretches beyond the Ministry and DHBs, to Crown entities, primary health organisations (PHOs), public health units (PHUs), private non-governmental providers, Māori and Pacific providers and independent 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-governmental organisations (NGOs) and consumer bodies that provide services and advocate for the interests of various groups, along with more formal advocacy and inquiry boards, committees and entities.

Figure 1: Structure of the New Zealand health and disability sector



Statutory framework

The New Zealand health and disability system's statutory framework is made up of over 20 pieces of legislation. The most significant are the New Zealand Public Health and Disability Act 2000, the Health Act 1956 and the Crown Entities Act 2004.

New Zealand Public Health and Disability Act 2000

The NZPHD Act establishes the structure underlying public sector funding and the organisation of health and disability services. It establishes district health boards (DHBs) and certain Crown entities, and sets out the duties and roles of key participants, including the Minister of Health and Ministerial advisory committees.

The NZPHD Act also sets the strategic direction and goals for health and disability services in New Zealand. These include:

- improving health and disability outcomes for all New Zealanders
- reducing disparities by improving the health of Māori and other population groups
- providing a community voice in personal health, public health, and disability support services
- facilitating access to, and the dissemination of information for, the delivery of health and disability services in New Zealand.

Health Act 1956

The Health Act sets out the roles and responsibilities of individuals to safeguard public health, including the Minister of Health, 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.

Crown Entities Act 2004

Many of the organisations that provide health services, including DHBs, are Crown entities. The Crown Entities Act provides the fundamental statutory framework for the establishment, governance, and operation of Crown entities. It clarifies accountability relationships and reporting requirements between Crown entities, their board members, responsible Ministers, and the House of Representatives.

Details of other legislation in the statutory framework are provided in Appendix 1.

Funding the system

The system is funded mainly from Vote Health, totalling just over \$13.95 billion in 2011/12. However, other significant funding sources do exist, including other government agencies (most notably ACC), local government, and private sources such as insurance and out-of-pocket payments.

The following Vote Health funding arrangements have evolved over time to manage the risks and complexities inherent in a large, semi-devolved system:

- a negotiated Vote Health envelope within which risks and pressures must be managed
- a Vote-held risk reserve to manage between-budget risks and pressures
- the ability to carry forward unspent funds under some circumstances
- an indicative three-year funding allocation
- annual formula-based adjustments for inflation and demographic change made from within the envelope.

The Ministry allocates more than three-quarters of the public funds it manages through Vote Health to DHBs. DHBs use this funding to plan, purchase and provide health services within their areas, including public hospitals and the majority of public health services.

Most of the remaining public funding provided to the Ministry of Health (approximately 20 percent) is used to fund important national services such as disability support services, public health services, specific screening programmes, mental health services, elective services, Well Child and primary maternity services, Māori health services and postgraduate clinical education/training. In 2010/11, the Ministry directly purchased about \$2 billion of health and disability services. Over time, it is expected that some of these services will be devolved nationally, while some services currently purchased by DHBs may be planned and purchased at a national level.

About 1.5 percent of Vote Health funding is spent on the Ministry's functions in support of the sector and government (almost \$205 million for 2011/12).

2 Minister of Health

The Minister of Health has overall responsibility for the health and disability system. The Minister's functions, duties, responsibilities and powers are provided for in the New Zealand Public Health and Disability Act 2000 (the NZPHD Act) and other legislation.

Strategic oversight

The Minister is responsible for strategies that provide a framework for the system and for reporting on their implementation to Parliament. The four key strategies currently in place are:

- the New Zealand Health Strategy
- the New Zealand Disability Strategy (responsibility is shared with the Minister for Disability Issues)
- He Korowai Oranga: the Māori Health Strategy
- the Primary Health Care Strategy.

There is no statutory requirement that these documents be reviewed. However, if the New Zealand Health Strategy and the New Zealand Disability Strategy are reviewed, the NZPHD Act requires consultation with appropriate organisations and individuals.

Levers across the health system

There are various levers in the system which the Minister, or the Ministry under the Minister's direction/delegation, can use to influence or direct activity. As it is a devolved system, many of the day-to-day functions and detailed decisions are exercised at a local level.

Ministerial advisory committees

Health legislation requires the Minister establish a number of compulsory committees and also allows for the establishment of discretionary committees (eg, the National Health Board and Health Workforce New Zealand). These committees provide the Minister with independent expert advice, and offer a forum for representatives of the sector to have a role in decision-making.

These committees are appointed by, and report directly to, the Minister. They are discussed further in Chapter 4.

DHBs and other Crown entities

The Minister has a number of responsibilities with respect to DHBs and other Crown entities. These include:

- responsibility for reviewing DHBs' and other health Crown entities' performance against objectives agreed with the Government
- giving consent and approval for DHBs' official planning documents (eg, Annual Plans and Regional Strategic Plans)
- reviewing and commenting on DHBs' and health Crown entities' Statements of Intent
- appointing members, Deputy Chairs and Chairs to DHB and health Crown entity boards.

The Minister informs DHBs and Crown entities of the Government's expectations and requirements through an annual letter of expectations, usually sent in December each year. An enduring letter of expectations also applies to all entities across the state sector, and focuses on the need to achieve value for money and strong performance.

The Minister also has a number of statutory powers which are generally exercised less frequently. These include:

- directing DHBs and health Crown entities to give effect to government policy (including, for DHBs, supporting government policy on improving the effectiveness and efficiency of the sector)
- requiring DHBs to provide or arrange for the provision of certain services
- stating how DHBs must obtain administrative, support and procurement services
- appointing Crown monitors to sit on DHB boards
- dismissing DHB boards and replacing them with Commissioners.

Appointments

For each of the 20 DHB boards, seven members are elected by the community every three years (concurrently with local elections), and up to four members are appointed by the Minister. The Minister also appoints each Chair and Deputy Chair from among the elected and appointed members.

The Minister also makes appointments to other Crown entity boards, and may appoint a Chair and Deputy Chair from among each board's members. The only exception is the Health and Disability Commissioner, who is appointed by the Governor-General on the advice of the Minister of Health.

Current DHB and Crown entity Chairs, Deputy Chairs and Chief Executives are listed on pages 21 and 28 respectively.

DHB and health Crown entity board members are typically appointed for terms of three years (the Health and Disability Commissioner is typically appointed for a five-year term). Vacancies in board member positions, including elected member positions on DHBs, can be filled by the Minister at any time. All members can be reappointed at the expiry of their terms (up to a maximum of nine consecutive years in the case of DHBs).

The role of DHBs is outlined in more detail in Chapter 5, and that of Crown entities in Chapter 6.

Other statutory positions/bodies

The Minister also makes a range of other appointments to statutory roles and committees, including: District Inspectors of Mental Health; the 16 health regulatory authorities responsible for the registration and oversight of health practitioners (eg, the Medical Council and the Nursing Council); a range of ethics committees; and the Health Practitioners Disciplinary Tribunal, a shared disciplinary body for all health professions.

The roles of these bodies are described more fully under 'Ministerial Committees, Tribunals, Councils and Inspectors' in Appendix 2.

Health emergencies

The Minister of Health has the power to declare health emergencies under the Health Act. This has the effect of unlocking various emergency powers for statutory officers across the sector, such as Medical Officers of Health. The Prime Minister, in consultation with the Minister of Health, has the power to issue an epidemic notice under the Epidemic Preparedness Act 2006 which allows a broader range of possible responses.

Health inquiries

The Minister has the power under the NZPHD Act to order inquiries into the funding or provision of health and/or disability support services, the management of any publicly-owned health and disability organisation, or into a complaint or matter that has arisen. This can be done through either a Commission of Inquiry or an inquiry board, which conduct the inquiry (or investigation, in the case of a Commission) and report back to the Minister.

3 The Ministry of Health

The Ministry is the Government's principal agent in New Zealand's health and disability system, and has overall responsibility for the management and development of that system.

The Ministry acts as the Minister of Health's principal advisor on health policy, thereby playing an important role in supporting effective decision-making. At the same time, the Ministry has a role within the health sector as a funder, purchaser and regulator of health and disability services. In this way, the Ministry provides leadership across the system and is the Government's primary agent for driving performance improvements within the system. The Ministry also has a wider role in coordinating action with other government agencies to deliver on the Government's agenda across the spectrum of social sector services.

As well as its key relationships with the Government and the health and disability system, the Ministry aspires to be a trusted and respected source of reliable and useful information about health and disability matters for all New Zealanders and the wider international community.

The Ministry's core functions

The Ministry seeks to improve, promote and protect the health of New Zealanders by:

- advising the Minister on policy, including advice on improving health outcomes, reducing disparities, ensuring fairness and increasing participation; nationwide planning, coordination and collaboration across the sector; and the implementation of the four key strategies currently in place (Health, Disability, Māori Health, and Primary Health Care)
- acting on behalf of the Minister to advise, fund, monitor and improve the performance of health sector Crown entities and DHBs, which are responsible for the health of their local communities
- purchasing health support services on behalf of the Crown, including public health interventions, disability support, and screening, maternity and ambulance services
- administering, implementing and enforcing legislation and regulations on behalf of the Crown, and meeting legislative requirements
- providing key infrastructural support to the health and disability system, especially through the provision of national information systems and a payments service
- servicing Ministers' offices and ministerial advisory committees.

Our priorities

The Ministry's overarching priority is that the health and disability system, and the quality of the care it provides, be constantly improving.

The health targets, a set of six national performance measures, provide a clear and specific focus for improving health and the quality of health care at local and national levels. They provide a way of measuring whether or not the health and disability system is delivering improvements in the health of New Zealanders and in their access to the services they need. The current six health targets are:

- shorter stays in emergency departments
- improved access to elective surgery
- shorter waits for cancer treatment
- increased immunisation
- better help for smokers to quit
- better diabetes and cardiovascular services (to be rebranded in 2012 as "More heart and diabetes checks").

These six targets represent a balance between public access to hospital care when it is needed – for the important areas of elective surgery, cancer treatment and emergency medicine – and preventative action to limit the damage from smoking, communicable diseases and chronic disease.

A review of the health targets is currently being undertaken for implementation in 2012/13 to ensure the mix of targets reflects the areas of greatest priority for driving improvements.

In addition to the health targets, the following are currently priority areas for the Ministry's short- and medium-term work programme:

- bringing health services closer to home
- improving the health and independence of older people
- strengthening the health workforce
- improving value for money.

These four Government priorities are dealt with in greater detail in the 'Operating Intentions' section of the Ministry's Statement of Intent 2011–14. The Ministry is also working across Government on implementing the Whānau Ora programme and responding to the Canterbury earthquakes.

Improving capability and performance

Structure and resourcing

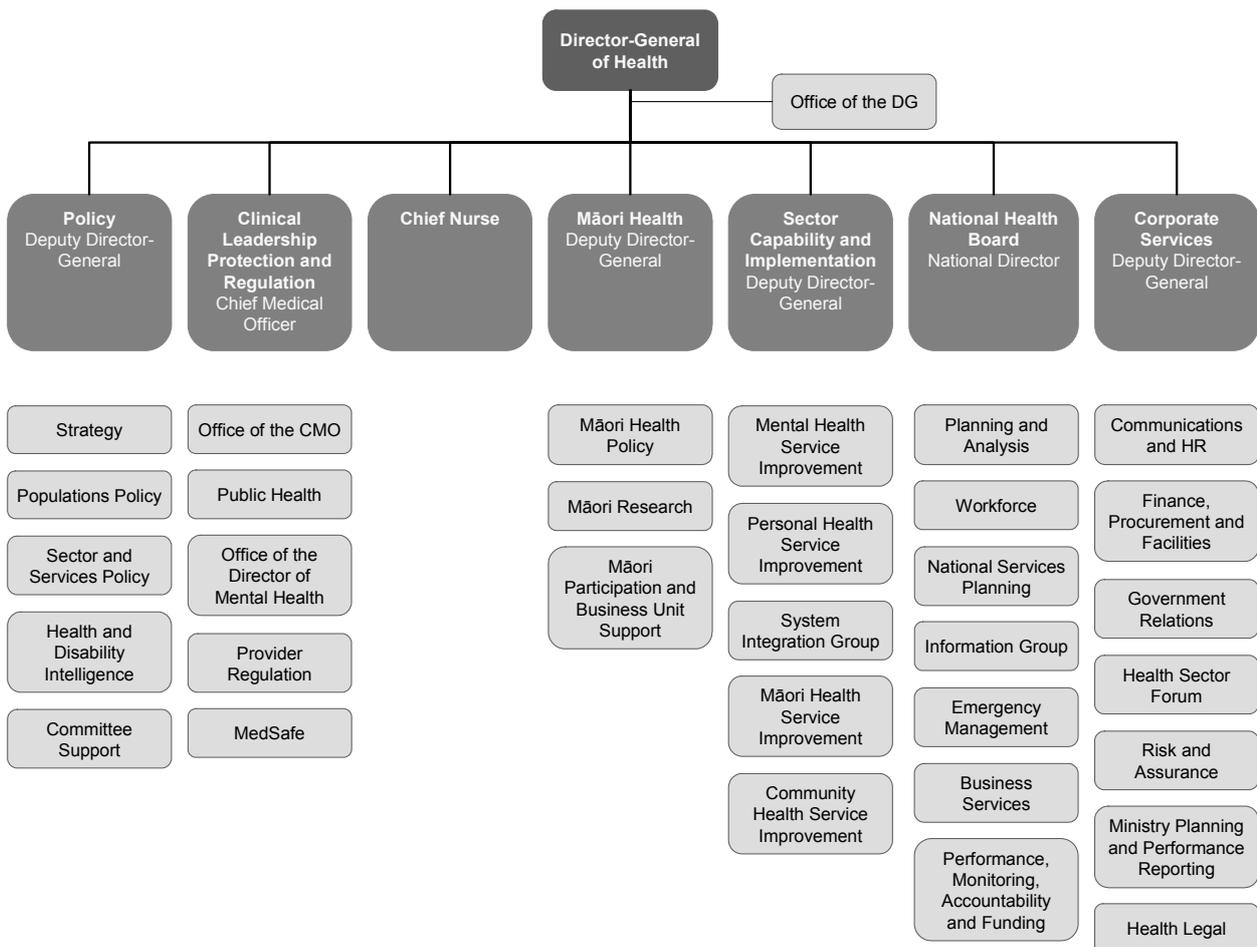
In recent months the Ministry has implemented significant changes to the structure of the organisation to better support the Government's reforms and deliver on key priorities. As a result of these changes and the increased focus on key priorities, the Ministry was able to reduce the full time equivalent (FTE) count from 1338 at the start of the 2010/11 year to 1156 FTEs by its close.

The new structure supports improved flexibility to respond to changing demands, through greater flexibility in the allocation of human resource to where it is needed.

Improving cost-effectiveness

As part of building capacity to carry out its work more effectively, the Ministry is committed to improving the cost-effectiveness of its operations. This means doing more, more effectively, for less. Extensive work has been done within the Ministry to increase the effectiveness of the policy and regulatory roles through restructuring both functions, including the consolidation of relevant business units in 2011.

Figure 2: Structure of the Ministry of Health



Statutory positions

Director-General of Health

The Director-General of Health is the chief executive of the Ministry and, like all other public service chief executives, is appointed on a fixed term contract by the State Services Commissioner under the State Sector Act 1988. In addition to responsibilities in the State Sector Act, the Director-General of Health 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 authorising the use of special powers for infectious disease control under the Health Act 1956
- certifying providers under the Health and Disability Services (Safety) Act 2001
- issuing guidelines under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and other acts.

Dr Kevin Woods is the Director-General of Health.

Director of Mental Health

The positions of Director and Deputy Director of Mental Health are both provided for in the Mental Health (Compulsory Assessment and Treatment) Act 1992. The Director of Mental Health is responsible for the general administration of the Act under the direction of the Minister and Director-General. The Deputy Director of Mental Health is required to perform such duties as the Director may require.

Dr John Crawshaw is the Director of Mental Health. Dr Susanna Every-Palmer is the Deputy Director of Mental Health.

Director of Public Health

The Director of Public Health position is provided for in the Health Act 1956. The Director of Public Health has the authority to independently advise the Director-General and Minister on any matter relating to public health, and also provides national public health professional leadership, and professional support and oversight for district Medical Officers of Health.

Dr Mark Jacobs is the Director of Public Health, and Darren Hunt and Fran McGrath are the Deputy Directors of Public Health.

Chief Financial Officer

The Public Finance Act 1989 requires all departments to have a Chief Financial Officer responsible for signing departments' Statements of Intent and Annual accounts. The Chief Financial Officer ensures that internal controls are effective and efficient.

Richard Morris is the Chief Financial Officer.

Executive Leadership Team

The Ministry's Executive Leadership Team (ELT) focuses on strategic management, corporate governance, and organisation performance.

ELT supports the Director-General of Health by:

- setting the Ministry's strategic direction and priorities within the context of the Government's policy objectives for the health and disability system
- ensuring the Ministry delivers on those strategies and goals by allocating departmental financial and non-financial resources, monitoring the organisation's performance and accounting for the use of publicly funded resources
- ensuring the Ministry has the capacity and capability to meet government objectives. This includes the people, information, structures, relationships, resources, culture, leadership, and systems to fulfil the government's directions in the medium and long term
- supporting the Director-General's financial and operational delegations by providing advice on key matters of health and disability public policy and implementation.

ELT membership is decided by the Director-General of Health, and includes:

- Dr Kevin Woods: Director-General of Health and Chief Executive
- Barbara Phillips: Deputy Director-General, Corporate Services
- Margie Apa: Deputy Director-General, Sector Capability and Implementation
- Chai Chuah: National Director, National Health Board
- Teresa Wall: Deputy Director-General, Māori Health
- David Wood: Acting Deputy Director-General, Policy
- Dr Don Mackie: Chief Medical Officer, Clinical Leadership, Protection and Regulation
- Dr Jane O'Malley: Chief Nurse.

Business units

Policy

The Policy Business Unit is the lead business unit for developing and providing policy advice to the Minister, and carrying out related policy functions in the Ministry's areas of responsibility. The Policy Business Unit comprises the following five groups and key functions.

- Strategy – developing advice on improving the medium to long-term performance of the overall health and disability system, and advice on overarching health and disability strategy.
- Populations policy – developing policy on issues that affect the health of particular ethnic and demographic groups in New Zealand. These groups include those with disabilities, Pacific peoples, older people, children and youth, maternity, and emerging populations.

- Sector and Services Policy – developing policy on issues surrounding the service settings and frameworks, including legislative frameworks, within which health-related services are delivered.
- Health and Disability Intelligence – providing focused information and analysis to support policy development and external sector information needs.
- Committee Support – providing secretariat and advisory support to the National Health Committee (NHC), the Advisory Committee on Assisted Reproductive Technology (ACART), and the National Ethics Advisory Committee (NEAC).

Sector Capability and Implementation

The Sector Capability and Implementation (SCI) Business Unit is responsible for ensuring the national programmes linked to the achievement of the Health Targets and related priority areas are designed and implemented efficiently and effectively.

Its core functions are specifying the initiatives or services required for implementation of specific priority areas of focus; and developing, managing, coordinating and overseeing programmes of work including those delivered in conjunction with the sector.

Current examples of SCI's work include Primary Health Care; National Cancer Control (including bowel screening implementation); Tobacco Control; Oral Health; Māori Development and Population Health; Pacific Development; Mental Health and Addictions (including problem gambling); Immunisation; Clinical Improvement and Productivity; and Child and Family Services.

Clinical Leadership, Protection, and Regulation (CLPR)

The CLPR Business Unit, led by the Chief Medical Officer, provides leadership and advice on overarching clinical matters within the Ministry, and leadership on key issues in the health and disability sector.

CLPR's clinical leadership functions include:

- dealing with 'medical management' questions requiring system responses – for example, advice on dealing with Health and Disability Commissioner and coroners' reports, and ACC treatment injury notifications
- maintaining a national overview of clinical issues from the Ministry's perspective
- providing clinical input and advice into wider Ministry work
- linking closely with the sector.

CLPR has several key statutory functions related to health protection. These include the roles of the Directors of Public Health and Mental Health, which both carry important leadership and decision-making responsibilities. CLPR also has responsibility for the following core regulatory functions:

- the New Zealand Medicines and Medical Devices Safety Authority (Medsafe), which is responsible for the regulation of therapeutic products¹
- provider regulation (HealthCERT and Medicines Control). HealthCERT is responsible for ensuring hospitals, rest homes and residential disability care facilities provide safe and reasonable levels of service for consumers. Medicines Control is a regulatory team that oversees the local distribution chain of medicines and controlled drugs within New Zealand.

Chief Nurse

The Chief Nurse has a strong focus on providing clinical leadership across the Ministry and the sector.

The role of the Chief Nurse is to provide support and advice to the Director-General on nursing issues that are important to the Ministry, the Minister and the health and disability sector; to provide expert input into health services planning through collaborative clinical leadership; and to provide clinical leadership and advice across government and the health and disability sector.

The Chief Nurse has responsibility for the nursing work programme.

National Health Board

The National Health Board Business Unit (NHBBU) supports the National Health Board in its role of overcoming the challenges facing our health system, and improving the quality, safety and sustainability of health care for New Zealanders. The responsibilities of the NHBBU are:

- funding monitoring and planning of DHBs, including annual planning and funding rounds
- the planning and funding of designated national services, including DHB regional service planning and arbitration over regional disputes
- stronger alignment of service, capital and capacity planning
- strengthening and accelerating the linkages between IT, workforce and facilities capacity investment
- supporting the Government initiative to reduce bureaucracy, so savings can be invested in frontline services.

¹ In June 2011, the New Zealand and Australian governments agreed to proceed with a joint scheme for the regulation of therapeutic goods. Over time, a single regulatory agency, the Australia New Zealand Therapeutic Products Agency, will absorb Medsafe.

Māori Health

The Māori Health Business Unit is the primary policy advisor on Māori health. The work of the Māori Health Business Unit includes:

- building the evidence base to improve the health of Māori
- implementing Whānau Ora
- improving health sector performance for Māori
- developing policy settings to support Māori participation in the sector at all levels
- supporting Māori providers in the health and disability sector
- supporting the health sector implementation of programmes to improve the health of Māori
- responding to Waitangi Tribunal claims.

Corporate Services

The Corporate Services Business Unit supports the Ministry, the Minister and the public by providing a range of centralised advice and services.

Examples of Corporate Services' work include:

- strategic and business planning linked to Ministry-wide priorities
- communications advice and publishing (both print and web)
- managing and supporting the flow of information to the Ministers' offices
- provision of legal advice for the Ministry
- Human Resource services from payroll through to organisational development
- managing the annual budget process.

Other leadership within the Ministry

Clinical directors

Clinical directors are experts who oversee the implementation of a national service framework or major clinical or service strategy, and provide advice to the Government on their service or area of clinical expertise. Their role is to spearhead change and act as an advocate for those national services or strategies within the Ministry of Health and across the sector, and they also represent New Zealand internationally.

The clinical directors are:

- Karen Evison – Tobacco Control (Acting)
- Dr John Childs – Cancer
- Dr Mike Ardagh – Emergency Department Services
- Dr Brandon Orr-Walker – Diabetes and Cardiovascular Disease
- Dr Api Talemaitoga – Pacific Health
- Elective Services – [Position currently vacant]
- Dr David Theobald – National Clinical Quality Lead (Gastrointestinal Endoscopy)
- Dr Chris Wong – Screening (Acting).

Chief advisors

Chief advisors are recognised leaders in their fields and have extensive experience across policy and strategy formation, implementation and management, as well as clinical or health professional practice.

The chief advisors are:

- Dr Pat Tuohy – Child and Youth
- Dr Jim Primrose – Primary Health Care
- Dr David St George – Integrative Care
- Lester Mundell – Disability Services
- Dr John Holmes – Population Health
- Wi Keelan – Māori Health
- Gillian Grew – Services
- Dr Robyn Haisman-Welsh – Oral Health
- Shankar Sankaran – Older People's Health
- Dr John Crawshaw – Mental Health.

4 Ministerial Advisory Committees

Ministerial advisory committees provide the Minister with independent expert advice, and offer a forum for representatives of the sector to have a role in decision-making. Some committees are mandatory under legislation, and others may be formed at the Minister's discretion (under general legislative powers, or as ad hoc committees).

National Health Board and subcommittees

The National Health Board (NHB) and its two subcommittees (the Capital Investment Committee and the IT Health Board) were established to improve the quality, safety and sustainability of health care for New Zealanders. These committees, along with Health Workforce New Zealand (see below), work with the Ministry to consolidate planning, funding, workforce planning and capital investment, as well as supervise the billions of dollars in public funding spent on hospitals, primary health services and important national health services.

NHB

The NHB is appointed by the Minister, and is supported by a dedicated branded business unit within the Ministry of Health. The NHB is responsible for overseeing the NHB Business Unit's work programme, which includes:

- funding, monitoring and planning of DHBs, including annual planning and funding rounds
- the planning and funding of designated national services, including DHB regional service planning and arbitration over regional disputes
- stronger alignment of service, capital and capacity planning
- strengthening and accelerating the linkages between IT, workforce and facilities capacity investment
- supporting the Government initiative to reduce bureaucracy.

Capital Investment Committee

The Capital Investment Committee is a sub-committee of the NHB. The Committee's primary objective is driving better investment decisions in the health system through planning and prioritisation for capital funding and investment in the health sector, along with advising on investment and infrastructure matters to support the Government's service planning direction.

IT Health Board

The IT Health Board, also a sub-committee of the NHB, provides strategic leadership on the implementation and use of information and information technology systems across the sector, and ensures IT strategy is reflected in capital allocation and capacity planning.

Health Workforce New Zealand

Health Workforce New Zealand (HWNZ) has overall responsibility for planning and development of the health workforce, ensuring that staffing issues are aligned with planning on delivery of services and that New Zealand's health care workforce is fit for purpose. HWNZ is directed by an independent board comprising senior clinicians and health sector leaders, appointed by and reporting directly to the Minister of Health. Its day-to-day work is carried out by a unit within the NHB Business Unit, headed by a director who reports to the National Director. The work of the unit is divided into three areas: intelligence and planning; investment relationships and purchasing; and workforce innovation programmes.

National Health Committee

The National Health Committee (NHC) provides the Minister with independent advice on a broad spectrum of health and disability issues, and is explicitly responsible for providing advice on the kinds, and relative priorities, of public health services that should be publicly funded. Its current focus is strengthening the prioritisation of new and existing technologies and interventions, to provide the New Zealand people and the health sector with greater value for the money invested in health. The NHC incorporates the Public Health Advisory Committee, which provides public health advice.

Information on further advisory committees (eg, the National Ethics Advisory Committee) is provided in Appendix 2.

5 District Health Boards

District health boards (DHBs) are responsible for providing or funding a specified range of health services in their district. Disability support services and some health services are funded and purchased nationally by the Ministry of Health, and usually delivered through DHBs. Public hospitals and other public health services are owned and funded by DHBs.

The NZPHD Act created DHBs and lays 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 in order to meet local, regional, and national needs
- promoting effective care or support of 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 health disparities by improving health outcomes for Māori and other population groups, and to reduce – with a view toward elimination – health outcome disparities between various population groups.

There are currently 20 DHBs in New Zealand (see Figure 3). They are required to plan and deliver services regionally, as well as in their own individual areas.

DHBs are expected to show a sense of social responsibility; to recognise and respect the principles of the Treaty of Waitangi; 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 have a role in implementing He Korowai Oranga (the Māori health strategy), which provides a framework for action to improve Māori health and reduce disparities; and have specific responsibilities for actions in Whakatātaka Tuarua, the second Māori Health Action Plan.

DHB Chairs, Deputy Chairs and Chief Executive Officers are listed in Table 1.

Figure 3: DHB regional boundaries



Table 1: DHB office holders, Chief Executive Officers, and 2010/11 financial performance

DHB	Chair (elected/appointed)	Deputy chair (elected/appointed)	Chief Executive	2010/11 surplus/(deficit)
Northland	Tony Norman (appointed)	Sally Macauley (elected)	Dr Nick Chamberlain	\$0.67 million
Waitemata	Dr Lester Levy (appointed)	Max Abbott (elected)	Dr Dale Bramley	\$4.31 million
Auckland	Dr Lester Levy (appointed)	Lee Mathias (elected)	Garry Smith	\$0.14 million
Counties Manukau	Prof Gregor Coster (appointed)	Jan Dawson (appointed)	Geraint Martin	\$4.86 million
Waikato	Prof Graeme Milne (appointed)	Sally Christie (elected)	Craig Climo	\$10.61 million
Lakes	Deryck Shaw (appointed)	Lyall Thurston (elected)	Cathy Cooney	(\$3.33 million)
Bay of Plenty	Sally Webb (appointed)	Jeff Williams (appointed)	Phil Cammish	\$0.06 million
Tairāwhiti	David Scott (appointed)	Barbara Clarke (elected)	Jim Green	(\$3.24 million)
Taranaki	Mary Bourke (appointed)	Peter Catt (elected)	Tony Foulkes	\$1.50 million
Hawke's Bay	Kevin Atkinson (elected)	Ngāhiwi Tomoana (appointed)	Dr Kevin Snee	\$5.27 million
Whanganui	Kate Joblin (elected)	Phil Sunderland (appointed)	Julie Patterson	(\$2.78 million)
MidCentral	Phil Sunderland (appointed)	Kate Joblin (appointed)	Murray Georgel	\$9.62 million
Hutt Valley	Dr Virginia Hope (appointed)	Wayne Guppy (elected)	Graham Dyer	(\$2.87 million)
Capital and Coast	Dr Virginia Hope (elected)	Peter Glensor (appointed)	Mary Bonner	(\$31.59 million)
Wairarapa	Bob Francis (appointed)	Leanne Southey (appointed)	Tracey Adamson	(\$3.60 million)
Nelson Marlborough	Jenny Black (elected)	Ian McLennan (appointed)	John Peters	\$0.22 million
West Coast	Paul McCormack (appointed)	Peter Ballantyne (appointed)	David Meates	(\$6.84 million)
Canterbury	Bruce Matheson (appointed)	Peter Ballantyne (appointed)	David Meates	(\$0.11 million)
South Canterbury	Murray Cleverley (elected)	Ron Luxton (elected)	Chris Fleming	\$1.05 million
Southern	Joe Butterfield (appointed)	Paul Menzies (elected)	Lexie O'Shea (acting for Carole Heatly, who takes office in February 2012)	\$0.23 million

Shared services agencies

Shared services agencies allow DHBs to pool their resources to obtain common support services through jointly owned companies. These include:

- HealthAlliance NZ Ltd (Northern region)
- Health Share Ltd (Midland region)
- Central Region's Technical Advisory Services Ltd (CRTAS) (Central region)
- South Island Shared Service Agency Ltd (South Island region).

Services provided vary from company to company but include health service and funding planning, a range of information and analysis services, and provider audit functions. In addition, these agencies have provided a platform for further collaborative planning between DHBs. National collaboration on matters of shared interest (eg, employment relations) is directed through CRTAS. A national shared services agency, Health Benefits Ltd, has also been established to reduce the costs of DHBs through the efficient and effective delivery of administrative, support and procurement services for DHBs.

Funding and performance

The Service Coverage Schedule outlines the national minimum range and standard of services to be publicly funded, and DHBs are required to 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 specified services for their population from another DHB using a system known as 'inter-district flows'. Where these services are provided by another DHB a national agreed price is generally used, or alternately DHBs may agree some sort of local arrangement between themselves.

In general, DHBs have flexibility around the allocation of funding to specific services, and over service volumes, to reflect the needs of their populations. However in regard to mental health services, DHBs have ring fenced spending targets for this client group.

Each year the majority of DHBs' (and the Ministry's NDE) budgets are increased using 'contribution to cost pressures' (CCP) and demographic (demo) adjustors. These aim to accommodate inflationary pressures, and service demand pressures caused by population changes.

The CCP and demo funding increases maintain per capita service coverage and quality. Where the scope of services is increased (rather than just maintained), this is generally funded separately via new initiatives money, on top of the CCP and demo increases.

These arrangements reflect a funding environment where:

- a population based funding formula (known as PBFF) 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 and other indicators of high needs such as deprivation status and ethnicity
- DHBs have responsibility 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 of Health, 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.

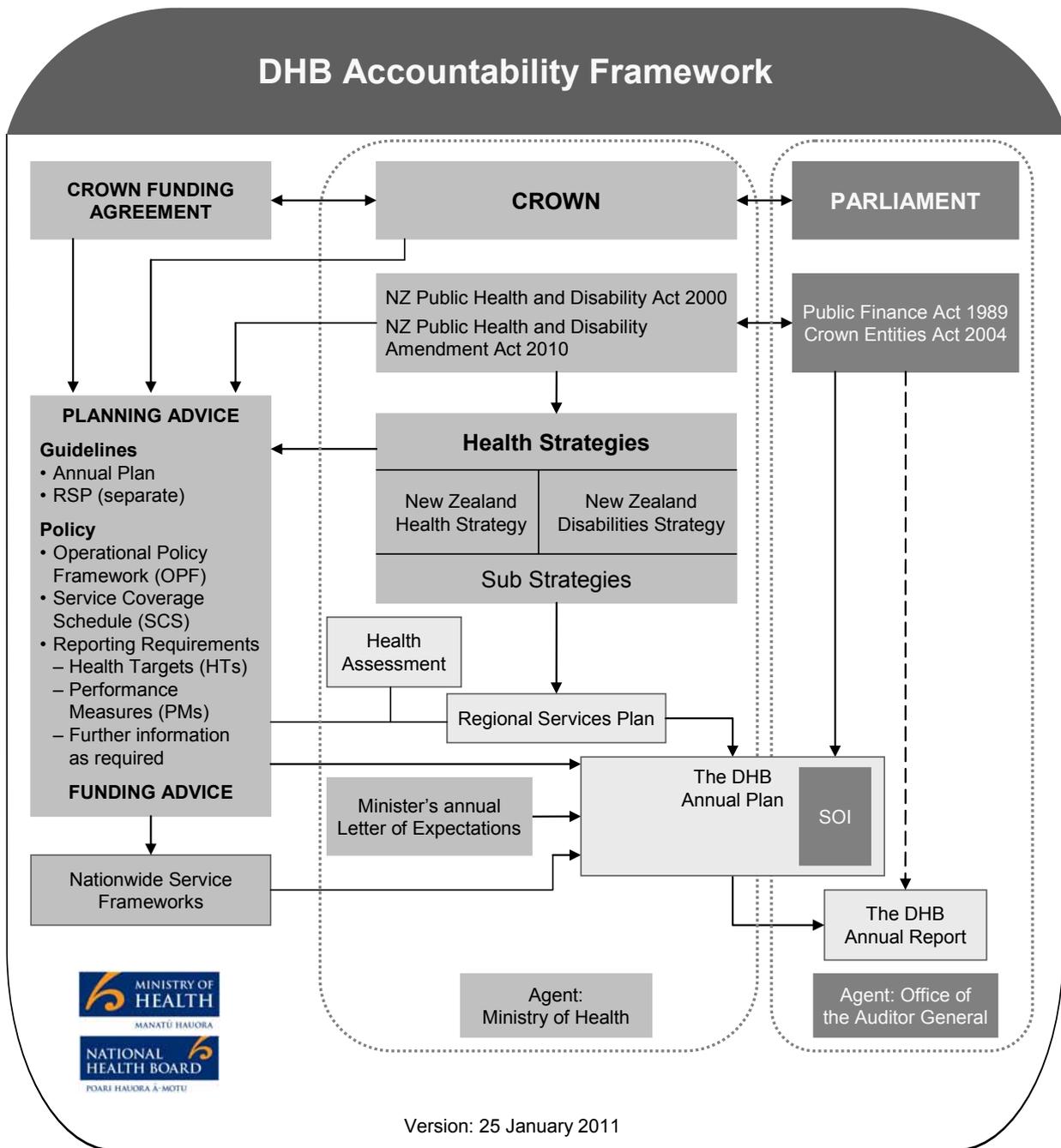
Accountability arrangements

The NZPHD Act, together with the New Zealand Public Health and Disability (Planning) Regulations 2011 and the Crown Entities Act, provide for the following accountability documents:

- **Crown Funding Agreements** (CFAs) are the principal contractual agreement between the Minister and each DHB, and contain DHB specific agreed performance targets, nationwide minimum service coverage, safety standards and mandatory business rules.
- **Regional Services Plans** (RSPs) based on collaborative planning for each of the four regions (Northern, Midland, Central, South Island), having both a strategic and an implementation element. The RSP must identify each regional DHB involved in each element of the plan, and must be updated annually. RSPs are agreed on by DHBs and the Minister.
- **Annual Plans** (APs) set out what each DHB intends to do over the next financial year and must be consistent with the RSP. The APs include how funding will be allocated across services and what targets and indicators will be used to measure performance. The Minister of Finance also has an interest in APs. This means the Minister of Finance's agreement is required, if decisions by DHBs involve significant fiscal risk, prior to the approval of the APs by the Minister of Health.
- **Statements of Intent** (SOIs) are extracted from the relevant sections of the DHB AP. DHBs are accountable to Parliament via their SOIs, and these must be tabled in Parliament, in accordance with the Crown Entities Act, at the beginning of the financial year.
- **Annual Reports** set out the DHB's performance in achieving the goals, indicators and targets contained in their APs and SOIs in the previous financial year, and how the funding was actually allocated.

The accountability framework can be visualised as in Figure 4.

Figure 4: DHB accountability framework



Planning and funding package

A key aspect in setting performance expectations is the development and release of an annual planning package. The DHB planning package contains agreed planning guidelines for the accountability documents described above, up-to-date policy, service coverage standards, performance targets and measures.

The Minister's 'letter of expectations', conveying the Government's key priorities for each year, is also sent to DHBs with the planning package. This letter, together with the planning package, is designed to ensure that planning appropriately reflects the service frameworks and policy priorities of the Minister of Health. DHBs and other stakeholders are consulted on the development of the planning package, followed by formal endorsement of the package by the Minister. The planning package is usually sent to DHBs by December to allow sufficient time for DHBs to embed new priorities in their planning processes. The DHB funding package is timetabled for release in November.

The DHB funding package includes the expected appropriation funding plus the forecast inter-district flow payments. Each DHB is sent an individual letter with a supporting spreadsheet that shows the calculations and results for all DHBs.

Employment relations

DHB Chief Executive Officers (CEOs) have the authority to enter into collective or individual employment agreements covering DHB employees. CEOs' 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 (MECAs) cover approximately 65 percent of all DHB employees, while seven regional MECAs cover a further 20 percent. The balance of DHB employees are covered by local collective or individual employment agreements.

Union density (membership as a proportion of the workforce) is very high (over 80 percent) in DHBs. 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.

Union density in the non-DHB health workforce is lower than in DHBs. MECAs exist for nurses and administrative staff in primary health providers, and for hospice staff (both negotiated by the New Zealand Nurses Organisation (NZNO)). Bargaining to cover those employed by Māori and iwi health care providers was initiated some time ago by NZNO, however the agreement has not been settled or ratified. Several larger providers (including DHBs in some cases) in the aged care and disability support services sectors have single employer collective agreements (SECAs) in place.

Role of the Ministry in employment relations

Under the NZPHD Act, CEOs must consult with the Director-General of Health prior to finalising the terms and conditions of a collective agreement. These obligations are explained further by specific Ministry guidelines (May 2009), the Operational Policy Framework document and the Government Expectations for Pay and Employment Conditions in the State Sector.

The Ministry's key roles in health sector employment relations activity are to: monitor local, regional and national bargaining; liaise and provide information; advice and feedback to the Minister of Health and the Minister of State Services, other government agencies and DHBs on employment relations activities and risks; and advise and report to the Committee of Ministers for State Sector Employment Relations.

Health Sector Relationship Agreement (HSRA)

A tripartite Health Sector Relationship Agreement (HSRA) between the Minister and the Ministry of Health, the DHBs, the Combined Trade Unions (CTU) and their major health affiliates (NZNO, Association of Salaried Medical Specialists, Public Service Association and Service and Food Workers' Union) was signed in 2008. The HSRA 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.

6 Crown Entities

In addition to DHBs, there are currently nine further health Crown entities, and one Crown-owned company. Crown entities are legally separate from the Crown and perform their functions at 'arm's length' from the Government, but remain accountable to the Minister for delivering on their statutory objectives.

The Crown Entities Act establishes three different types of Crown entity, as described in Table 2.

Following a recent State sector review, from 1 July 2012 the number of non-DHB health Crown entities will be reduced to six. The Alcohol Advisory Council, the Health Sponsorship Council, the Crown Health Financing Agency, and the Mental Health Commission will be disestablished, and a new Health Promotion Authority will be established as a Crown agent.

Performance and accountability

Crown entity performance is monitored by the Ministry. Like DHBs, Crown entities have a range of accountability documents in place, to guide and monitor their performance.

- **Output Agreements:** the principal contractual agreement between the Minister and each entity, containing entity-specific agreed performance targets.
- **Statements of Intent (SOIs):** outlining how the entity's funding will be allocated across services, and what targets and indicators will be used to measure performance. Entities are accountable to Parliament via their SOIs, and these must be tabled in Parliament, in accordance with the Crown Entities Act, at the beginning of the financial year.
- **Annual Reports:** setting out the entity's performance in achieving the goals, indicators and targets contained in their SOI, and how the funding was actually allocated.

Table 2: Crown entity classifications, office holders and chief executives

Type	Entity	Chair	Deputy Chair	Chief Executive Officer
<p>Crown agent Crown agents are entities whose functions pose high strategic, policy, contractual or fiscal risk, and are therefore subject to a significant degree of Ministerial control. Crown agents must, in most cases, give effect to government policy when directed to do so by the Minister. The Minister appoints board members, and has the power to remove a board member from office at his or her discretion.</p>	Crown Health Financing Agency	Alastair Scott	–	Graeme Bell
	Health Research Council of New Zealand	Robert Stewart	Prof Richard Beasley	Dr Robin Olds
	Health Quality and Safety Commission	Prof Alan Merry	Dr Peter Foley	Dr Janice Wilson
	Health Sponsorship Council	Hayden Wano	Dame Susan Devoy	Iain Potter
	New Zealand Blood Service	David Chamberlain	David Wright	Fiona Ritsma
	Pharmaceutical Management Agency (PHARMAC)	Stuart McLauchlan	–	Stefan Crausaz (acting)
<p>Autonomous Crown entity Autonomous Crown entities are subject to a lesser degree of Ministerial control than Crown agents. They must have regard to any policy direction given by the Minister. The Minister appoints board members, and can remove a board member from office for 'just cause'.</p>	Alcohol Advisory Council of New Zealand (ALAC)	Rea Wikaira	Trevor Shailer	Gerard Vaughan
	Mental Health Commission	Dr Lynne Lane (Chair Commissioner)	–	–
<p>Independent Crown entity Independent Crown entities typically have monitoring functions and require a high level of decision-making independence from Ministers. They are not subject to government policy directions. 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.</p>	Health and Disability Commissioner	Anthony Hill (Commissioner)	–	–
<p>Crown company Crown companies have the ability to have mixed commercial and non-commercial objectives (operating in a commercial manner in a public sector environment). They can have flexible ownership arrangements if desired. Directors are usually appointed by joint Ministers.</p>	Health Benefits Ltd	Ted van Arkel	–	Nigel Wilkinson

Crown agents

Crown Health Financing Agency (CHFA)

DHBs are not authorised to borrow from the private sector except for working capital for facilities; the CHFA, which replaced the Residual Health Management Unit in 2005, is the Crown's lender to the DHB sector. It provides DHBs with a range of term loan facilities broadly similar to a commercial lending organisation, and has established loan application, credit assessment and monitoring procedures. The CHFA has to approve DHB business cases before funds are provided, sets the terms and conditions of loans, and ensures repayment and compliance with loan conditions. The CHFA also assists the DHB sector to dispose of surplus property, either by buying surplus DHB property assets (and selling them on the open market) or by holding properties, and managing them until disposal. The CHFA also manages the Crown's residual legal liabilities with respect to the former area health boards.

In 2010/11, CHFA reported a total operating revenue of \$2.589 million (not including DHB loan monies), and total operating expenses of \$2.834 million (not including DHB loan monies) – a net deficit of \$245,000. In 2009/10 CHFA reported a net deficit of \$294,000, and in 2008/09 a net deficit of \$722,000. As at 30 June 2011, CHFA has equity of \$3.325 million.²

Under the Crown Entities Reform Bill, the CHFA is to be disestablished by 1 July 2012, and its functions transferred to the Ministry of Health and The Treasury.

Health Quality and Safety Commission (HQSC)

The HQSC was established in December 2010. Its objectives are to lead and coordinate work across the health and disability sector for the purposes of monitoring and improving the quality and safety of health and disability support services.

HQSC provides advice to the Minister on how quality and safety in health and disability support services may be improved; and is responsible for determining and reporting quality and safety indicators (such as serious and sentinel events) for health and disability support services. It also has a range of functions relating to mortality, including appointing and supporting mortality review committees.

In the first half of 2011, HQSC recorded total income of \$8.118 million, and total expenditure of \$5.021 million – a net surplus of \$3.097 million. At 30 June 2011, HQSC has equity of \$3.097 million.

² More detailed information on the financial performance of each entity is available in its Annual Report.

Health Research Council of New Zealand (HRC)

The HRC was established by the Health Research Council Act 1990. It is responsible for funding and coordinating health research, and fostering New Zealand's health research workforce.

The HRC funds a range of health research including biomedical, clinical, public health, health services, and Māori and Pacific research. Funding is largely provided through Vote Science and Innovation. It also funds a range of health research career development awards, and is responsible for creating the guidelines for accrediting ethics committees that assess research proposals.

In 2010/11, HRC recorded a total income of \$84.984 million (\$285,000 from Vote Health), and total expenditure of \$89.867 million – a net deficit of \$4.883 million. In 2009/10 it recorded a surplus of \$432,000; and in 2008/09 a surplus of \$1,317,000. As at 30 June 2011, HRC has equity of \$15.150 million.

Health Sponsorship Council (HSC)

The HSC was established by the Smoke-free Environments Act 1990. Its principal function is social marketing to promote health and encourage healthy attitudes and lifestyles. The HSC provides sponsorship for sporting, artistic, cultural and recreational organisations in return for the promotion of these messages, and increasingly uses a range of other channels to market healthy lifestyle options.

The HSC currently delivers four main programmes, aimed at:

- reducing the prevalence and incidence of smoking
- increasing safe behaviour in the sun
- minimising gambling harm
- reducing obesity and its associated illnesses through better nutrition and physical activity.

In 2010/11, HSC recorded total income of \$9.778 million (including the gambling levy), and total expenditure of \$11.665 million – a net deficit of \$1.187 million. In 2009/10 HSC reported a net surplus of \$580,000, and in 2008/09 a net surplus of \$197,000. As at 30 June 2011, HSC has equity of \$2.472 million.

Under the Crown Entities Reform Bill, the HSC is to be disestablished by 1 July 2012, and its functions (along with those of ALAC) transferred to a new Crown agent to be known as the Health Promotion Agency.

New Zealand Blood Service (NZBS)

The NZBS is responsible for managing the donation, collection, processing and supply of blood, blood products and related services. The NZBS's core activity is the safe, timely, high-quality and efficient provision of blood, and tissue typing services.

In 2010/11, NZBS recorded a total income of \$102.282 million (most of which is from DHBs), and total expenditure of \$93.03 million – a net surplus of \$9.252 million. NZBS's surpluses are typically distributed back to DHBs. In 2009/10, its surplus was \$1.587 million, and in 2008/09 \$3.308 million. As at 30 June 2011, NZBS has equity of \$34.905 million.

Pharmaceutical Management Agency (PHARMAC)

PHARMAC's primary objective is to secure the best health outcomes that are reasonably achievable from pharmaceutical treatment, within the funding provided. Its key functions are:

- administering the Pharmaceutical Schedule (ie, deciding which medicines are to be funded by the Government). The PHARMAC Board makes its decisions on which pharmaceuticals should be subsidised with input from their expert clinical advisory group, the Pharmacology and Therapeutics Advisory Committee (PTAC).
- managing the Community Pharmaceutical Budget on behalf of DHBs – determining national prices for some pharmaceuticals to be purchased by, and used in, DHB hospitals.

As a Crown agent, PHARMAC must give effect to government policy when directed by the Minister of Health. However, PHARMAC cannot legally be directed to purchase a pharmaceutical from a particular source or at a particular price, or to provide any pharmaceutical or pharmaceutical subsidy or other benefit to a named individual.

In 2010/11 PHARMAC recorded a total income of \$28.406 million, and total expenditure of \$22.041 million – a net surplus of \$6.365 million. In 2009/10 it reported a net surplus of \$1.231 million, and in 2008/09 a net deficit of \$6.079 million. As at 30 June 2011, PHARMAC has equity of \$14.912 million (including a \$10 million Pharmaceutical Budget Management tool).

Autonomous Crown entities

Alcohol Advisory Council of New Zealand (ALAC)

ALAC is established under the Alcohol Advisory Council Act 1976. Its primary objective is to encourage and promote moderation in the use of alcohol, and to develop and promote strategies that will reduce alcohol-related harm in New Zealand. It is funded by a levy on all alcohol manufactured or imported into New Zealand.

In 2010/11, ALAC reported a total income (from the alcohol levy, plus interest on assets) of \$12.476 million, and total expenditure of \$12.819 million – a net deficit of \$343,000. In 2009/10, its net deficit was \$144,000; and in 2008/09, \$86,000. As at 30 June 2011, ALAC has equity of \$1.124 million.

Under the Crown Entities Reform Bill, ALAC is to be disestablished by 1 July 2012, and its functions (along with those of the HSC) transferred to the new Health Promotion Agency.

Mental Health Commission (MHC)

The MHC was established in 1998 in response to the recommendations of the Mason Inquiry into Mental Health Services. The term of the MHC was initially due to end in 2007, but was subsequently extended.

The MHC is tasked with providing the government with independent advice on how well mental health and addiction services are meeting the needs of people. It acts as an advocate for the interests of people with mental illness and their families, and aims to promote better understanding of, and reduce the stigma and discrimination associated with, mental illness. The MHC also monitors implementation of the national mental health strategy and supports the development of integrated, effective, and efficient mental health services that meet the needs of service users and their families.

In 2010/11, the MHC recorded total revenue of \$2,867,877, and total expenditure of \$3,143,990 – a net deficit of \$276,113. In 2009/10, it recorded a net surplus of \$214,466; and in 2008/09, a net deficit of \$44,973. As at 30 June 2011, MHC has equity of \$96,026.

Under the Crown Entities Reform Bill, the MHC is to be disestablished by 1 July 2012. Its functions are to be transferred to the Health and Disability Commissioner, with a new Mental Health Commissioner position to be established within the HDC.

Independent Crown entities

Health and Disability Commissioner (HDC)

The office of the HDC was established under the Health and Disability Commissioner Act 1994. The HDC aims to promote and protect the rights of consumers of health and disability support services as specified in the Code of Health and Disability Services Consumers' Rights. It administers nationwide advocacy services, which promote the Code of Health and Disability Services Consumers' Rights and work alongside consumers to help 'put things right'. The HDC is also responsible for facilitating fair and simple resolution of complaints.

The HDC may, on the Commissioner's own initiative or at the Minister's request, advise the Minister on any matter relating to the rights of health and disability consumers, the administration of the Health and Disability Commissioner Act 1994, or the need for action to protect the rights of consumers.

In 2010/11, the HDC recorded a total income of \$9.35 million, and total expenditure of \$9.234 million – a net surplus of \$121,855. In 2009/10 it recorded a net deficit of \$39,112; and in 2009, a net deficit of \$42,148. As at 30 June 2011, HDC has equity of \$1.464 million.

Crown company

Health Benefits Limited (HBL)

HBL is a national shared services organisation formed to reduce costs and deliver savings through the effective and efficient delivery of administrative, support and procurement services for DHBs. This includes services such as financial management and information systems, procurement and supply chain, human resource and shared payroll, information technology and facilities management.

Savings made from these activities are to be reinvested into frontline health services and in many cases this will mean services can be maintained in the face of increasing costs and tight fiscal conditions.

While not a Crown entity under the Crown Entities Act 2004, HBL is a Crown-owned company. It is owned in equal shares by the Minister of Health and the Minister of Finance.

In 2010/11, HBL recorded a total income of \$5.751 million, and total expenditure of \$4.838 million – a net surplus of \$913,000. As at 30 June 2011, HBL has equity of \$1.213 million.

7 Other Organisations

Primary health organisations (PHOs)

PHOs are funded by DHBs to support the provision of essential primary health care services through general practices to those people who are enrolled with the PHO.

PHOs are one vehicle through which the Government's primary health care objectives, articulated through 'Better, Sooner, More Convenient' Primary Health Care, are implemented in local communities. As at July 2011, there were 32 PHOs that vary widely in size and structure, though all are not-for-profit organisations.

A PHO provides services either directly or through its provider members. These services should improve and maintain the health of the entire enrolled PHO population, as well as providing services in the community to restore people's health when they are unwell. The aim is to ensure GP services are better linked with other primary health services (such as allied health services) to ensure a seamless continuum of care, in particular to better manage long-term conditions.

Public health units

Regional public health services are delivered by 12 district health board-owned public health units (PHUs), and a range of non-government organisations. District health board-based services and non-government organisations each deliver about half of these services.

Public health units focus on environmental health, communicable disease control, tobacco control and health promotion programmes. Many of these services include a regulatory component performed by statutory officers appointed under various statutes, though principally under the Health Act 1956.

Statutory officers

Most statutory officers are designated by the Director-General of Health under the Health Act 1956. These officers – medical officers of health and health protection officers – are accountable to, and subject to direction from, the Director-General. This ensures central oversight of regulatory functions. The majority of these officers are employed in DHB-based public health units.

The Director-General also appoints statutory officers under a range of other Acts, in particular the Smoke-free Environments Act 1990, the Tuberculosis Act 1948 and the Hazardous Substances and New Organisms Act 1996. City and district councils also appoint environmental health officers under the Health Act, who assist councils to perform their environmental health functions under the Act.

Non-governmental organisations (NGOs)

NGOs receive significant funding (in the order of \$2 billion-\$4 billion per year) from both the Ministry of Health and DHBs. Many are non-profit and, along with providing services to consumers, are a valuable contact at community level.

NGOs have a long, well established record of contribution to New Zealand's health and disability service delivery. Health and disability 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, and include kaupapa services such as Māori and Pacific providers.

The Ministry and NGOs from the health and disability sector have a formalised relationship outlined in the Framework for Relations between the Ministry of Health and Health and Disability Non-governmental Organisations. To facilitate this relationship there is an NGO Working Group, and within the Ministry an NGO Desk.

8 International Linkages

The Ministry maintains active links with international health organisations and other health Ministries in relevant countries, to achieve the following goals:

- to protect New Zealand against international health threats such as pandemic influenza
- to learn from other countries' experiences, and international debate, on ways to organise, manage and deliver health services, including best practice and new innovations
- to provide support and assistance to less developed countries, in particular in the Pacific region. This demonstrates that New Zealand is a good global citizen, and recognises that health in Pacific nations strongly impacts on the health of Pacific populations in New Zealand.

The Minister of Health has a central role in this activity.

International contacts

The World Health Organization (WHO) 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 a member of WHO.

New Zealand also maintains links with the OECD (Organisation for Economic Cooperation and Development), APEC (Asia-Pacific Economic Cooperation), the Commonwealth Fund (a non-government organisation based in Washington, that conducts comparative health policy research), and other regional and global organisations.

The Commonwealth

New Zealand maintains links with health Ministers and authorities elsewhere in the Commonwealth. Regular Commonwealth Health Ministers Meetings occur prior to the World Health Assembly, the annual WHO health forum in Geneva, Switzerland, in May each year.

Australia

Meetings with Australian Ministers of Health occur regularly at the federal, state and territory levels, under the auspices of the Australian Standing Council on Health. This provides a forum for Ministers to discuss issues of mutual interest and is supported by an advisory body made up of Chief Executives from the states, territories and federal (Commonwealth) Departments of Health.

Pacific links

Hosted by WHO and the Secretariat of the Pacific Community, Pacific Health Ministers meet every two years to consider regional initiatives and collaboration on existing or emerging health issues. New Zealand and Australia are invited as observers to the meetings. The next meeting will be in mid-2013 in a Pacific country to be confirmed.

In addition to these Ministerial meetings, there are frequent contacts at officer level between the Ministry and its Pacific counterparts, often concerning requests for technical advice. The Ministry also participates in key regional initiatives, in areas such as pandemic preparedness and drinking water quality.

International conventions

There are two international treaties New Zealand is party to that specifically relate to health, and several others that have implications for health and disability (eg, concerning the rights of children, women, migrant workers, and people with disabilities).

The framework convention on tobacco control

The framework convention on tobacco control is the WHO's first international treaty. The World Health Assembly adopted the text in May 2003, and it came into force on 28 February 2005. Currently 168 out of 194 member countries of the WHO are signatories. New Zealand participated actively in its development, signed it in June 2003, and ratified it in January 2004. It is a relatively strong convention covering such issues as tobacco advertising, price and tax measures, and packaging and labelling of tobacco products.

The International Health Regulations (IHR)

New International Health Regulations (IHR) were adopted by the World Health Assembly in May 2005, and came into force on 15 June 2007. These regulations are binding on New Zealand, as they are on most WHO member states.

The IHR focus on the early detection and response to disease outbreaks and other public health events of international significance. They are a key mechanism to prevent and control the spread of disease between countries, and provide the primary international legal framework for both the WHO and its 194 member states to assess and respond to emerging international threats to public health. The adoption by WHO, and implementation by countries like New Zealand, is a critical part of both emergency preparedness and routine surveillance and control of communicable disease.

Under the IHR 2005, all countries need a national focal point as a whole of government communication channel with WHO and to oversee national preparedness for a wide range of public health threats. In New Zealand this role is undertaken by the Office of the Director of Public Health.

Other agreements

Reducing the harmful use of alcohol is currently under discussion by WHO members and may be the focus for a new international health convention in future.

Glossary

ACART	Advisory Committee on Assisted Reproductive Technologies
ACC	Accident Compensation Corporation
ALAC	Alcohol Advisory Council of New Zealand
AP	Annual Plan
CCNZ	Cancer Control New Zealand
CCP	Contribution to cost pressures
CFA	Crown Funding Agreement
CHFA	Crown Health Financing Agency
Demo	Demographic adjustor
DHB	District Health Board
ECART	Ethics Committee on Assisted Reproductive Technologies
FSANZ	Food Standards Australia New Zealand
HBL	Health Benefits Ltd
HDC	Health and Disability Commissioner
HDECs	Regional Health and Disability Ethics Committees
HPA	Health Promotion Authority
HPCA Act	Health Practitioners Competency Assurance Act
HRC	Health Research Council of New Zealand
HQSC	Health Quality and Safety Commission
HSC	Health Sponsorship Council
HSRA	Health Sector Relationship Agreement
IHR	International Health Regulations
MAAC	Medicines Assessment Advisory Committee
MARC	Medicines Adverse Reactions Committee
MCC	Medicines Classification Committee
Medsafe	New Zealand Medicines and Medical Devices Safety Authority (Ministry of Health)
MHC	Mental Health Commission
MHRT	Mental Health Review Tribunal
MRC	Medicines Review Committee
NEAC	National Ethics Advisory Committee
NGOs	Non-Governmental Organisations
NHB	National Health Board
NHC	National Health Committee
NRL	National Radiation Laboratory

NSDP	National Systems Development Programme
NZBS	New Zealand Blood Service
NZNO	New Zealand Nurses Organisation
NZPHD Act	New Zealand Public Health and Disability Act 2000
OPF	Operational Policy Framework
PBFF	Population Based Funding Formula
PGD Act	Plumbers, Gasfitters and Drainlayers Act 1976
PHO	Primary Health Organisation
PHU	Public Health Unit
RPAC	Radiation Protection Advisory Council
RSP	Regional Service Plan
SOI	Statement of Intent
WHO	World Health Organization

Appendix 1: Health Legislation

Alcohol Advisory Council Act 1976	This Act established the Alcohol Advisory Council of New Zealand (ALAC) to promote moderation in alcohol use and reduce the personal, social, and economic harm resulting from its misuse. The Act defines ALAC's functions and powers, and provides for its funding by a levy on alcoholic liquor.
Alcoholism and Drug Addiction Act 1966	This Act provides for the care and treatment of people with alcohol and drug addictions.
Burial and Cremation Act 1964	This Act outlines the law relating to the burial and cremation of the dead.
Cancer Registry Act 1993	This Act 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 for cancer prevention.
Children's Health Camp Dissolution Act 1999	This Act dissolved the Children's Health Camps Board, transferred its assets and liabilities to a foundation incorporated under Part 2 of the Charitable Trusts Act 1957, and provides for incidental matters.
Disabled Persons Community Welfare Act 1975, Part 2A	This Act sets out the right of persons in residential care to review of the adequacy of any disability services, and whether or not a person's disability services needs are appropriately met by the residential care received.
Epidemic Preparedness Act 2006	This Act provides statutory power for government agencies to prevent and respond to the outbreak of epidemics in New Zealand, and to respond to particular possible 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 to enable the relaxation of some statutory requirements that might not be capable of being complied with, or complied with fully, during an epidemic.
Health Act 1956	The current law relating to public health (as described on page 4).
Health and Disability Commissioner Act 1994	This Act aims to promote and protect the rights of health consumers and disability services 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	This Act aims to: <ul style="list-style-type: none"> (a) promote the safe provision of health and disability services to the public (b) enable the establishment of consistent and reasonable standards for providing health and disability services to the public safely (c) encourage providers of health and disability services to take responsibility for providing those services to the public safely (d) encourage providers of health and disability services to the public to improve continuously the quality of those services.

Health Benefits (Reciprocity with Australia) Act 1999	This Act provides for reciprocity with Australia in relation to pharmaceutical, hospital, and maternity benefits.
Health Benefits (Reciprocity with United Kingdom) Act 1982	This Act provides for reciprocity with the United Kingdom in relation to medical, hospital, and related benefits.
Health Practitioners Competence Assurance Act 2003	This Act aims to ensure health practitioners are competent and fit to practice their professions. It provides: <ul style="list-style-type: none"> (a) for a consistent accountability regime for all health professions (b) for the determination of the scope of practice within which each health practitioner is competent (c) for systems to ensure that no health practitioner practises outside his or her scope of practice (d) for power to restrict specified activities to particular classes of health practitioner (e) for certain protections for health practitioners who take part in protected quality assurance activities. <p>Note that additional health professions may become subject to this Act.</p>
Health Research Council Act 1990	This Act defines the functions and powers of the Health Research Council of New Zealand.
Health Sector (Transfers) Act 1993	The purposes of this Act are to: <ul style="list-style-type: none"> (a) provide for assets, liabilities, or functions within the public health and disability sector to be transferred to the Crown or to certain specified bodies within that sector (b) provide for the effect and the consequences of <ul style="list-style-type: none"> (i) transfers, in accordance with this Act, of assets, liabilities, or functions within the public health and disability sector (ii) sales or other dispositions of land by DHBs (c) permit DHBs, subject to specified conditions, to sell or dispose of land that is subject to trusts or certain other restrictions.
Human Tissue Act 2008	This Act governs the collection and use of human tissue to ensure that it is done in an appropriate way, without endangering the health and safety of members of the public and does not involve payment.
Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003	This Act 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	This Act covers the law relating to the manufacture, sale, and supply of medicines, medical devices, and related products.
Mental Health Commission Act 1998	This Act established the Mental Health Commission to implement the national mental health strategy and improve services and outcomes for people with mental illness and their families and caregivers.
Mental Health (Compulsory Assessment and Treatment) Act 1992	This Act defines the circumstances and conditions where persons may be subjected to compulsory psychiatric assessment and treatment. It defines and protects the rights of such persons, and generally defines the law relating to the assessment and treatment of persons suffering from mental disorders.

Misuse of Drugs Act 1975	This Act provides for the prevention of the misuse of drugs.
New Zealand Public Health and Disability Act 2000	The key piece of legislation in the health and disability system, this Act provides for the public funding and provision of personal health services, public health services, and disability support services, and establishes the publicly-owned health and disability organisations.
Radiation Protection Act 1965	An Act to consolidate and amend the Radioactive Substances Act 1949.
Smoke-free Environments Act 1990	This Act aims to: <ul style="list-style-type: none"> (a) reduce the exposure of people who do not themselves smoke to any detrimental effect on their health caused by smoking by others (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 (d) establish a Health Sponsorship Council.
Tuberculosis Act 1948	This Act provides for the treatment, care, and assistance of persons suffering or having suffered from tuberculosis, and for preventing the spread of tuberculosis.

Appendix 2: Other Ministerial Committees, Tribunals, Councils and Inspectors

This appendix provides a brief description of the roles, functions and statutory bases of those bodies and people the Minister of Health appoints which have not already been discussed. Some bodies also have members appointed in other ways, or by virtue of their job. The 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. It responds to applications to use, publish or disclose Māori women's aggregate data from the National Cervical Screening Register. It meets no more than four times per year.

National Cervical Screening Programme Review Committee

The National Cervical Screening Programme (NCSP) Review Committee's statutory functions are to review the operation of the NCSP and evaluate the service delivery and outcomes of the NCSP. The NCSP Review Committee consists of no more than three members.

Health Practitioners Competence Assurance Act 2003

Responsible authorities

There are currently 16 responsible authorities (often called health regulatory authorities) under the Health Practitioners Competence Assurance Act (HPCA Act), covering 21 health professions.

Each regulatory authority prescribes scopes of practice for its profession (these set the boundaries within which a practitioner can practice), prescribes necessary qualifications, registers practitioners and issues annual practising certificates. They also set standards of competence. The regulatory authorities, via professional conduct committees, can investigate individual practitioners' competence and conduct.

These authorities are funded by their professions and have their own staff and premises. While the Minister of Health has a power of audit, the regulatory authorities have autonomy in making decisions such as setting scopes of practice or fees. The notices which give effect to those decisions are 'deemed regulations'.

The Minister of Health appoints the members of all regulatory authorities. There is a power in the HPCA Act for the Minister to make regulations so that a proportion of the health professional members of an authority would be appointed according to elections held among the profession. At present, such regulations exist for the Nursing Council (three elected members) and the Medical Council (four elected members).

Health Practitioners Disciplinary Tribunal

The Health Practitioners Disciplinary Tribunal hears and determines more serious cases against health practitioners. It comprises a Chair, three Deputy Chairs, and a panel of 131 laypeople and health practitioners. However, only the Chair or a Deputy, one layperson and three practitioners of the relevant profession sit on each case.

Human Assisted Reproductive Technology (HART) Act 2004

Advisory Committee on Assisted Reproductive Technology

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

- issuing guidelines and advice to the Ethics Committee on Assisted Reproductive Technology on assisted reproductive procedures or human reproductive research
- providing the Minister of Health with advice on assisted reproductive procedure and human reproductive research
- any other function the Minister of Health assigns to it.

Ethics Committee on Assisted Reproductive Technology

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

- considering and determining applications for assisted reproductive procedures or 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 that the Minister of Health 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 (MARC)

The Medicines Adverse Reactions Committee (MARC) advises the Minister of Health on medicine safety issues and reviews reports on adverse reactions.

Medicines Assessment Advisory Committee (MAAC)

The terms of reference for this committee are to:

- assess and advise on the efficacy, safety and quality of new medicines
- make recommendations, in relation to the Medicines Regulations, on the classification of new medicines
- consider and advise the Minister on the suitability of medicines for distribution in New Zealand
- consider and advise the Minister on any other matters relating to new medicines or the distribution of medicines.

Medicines Classification Committee (MCC)

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

The MCC membership is to include two nominees each from the New Zealand Medical Association, the Pharmaceutical Society of New Zealand, and the Ministry of Health (one of whom is required to be the Chair).

Medicines Review Committee (MRC)

The Medicines Review Committee (MRC) inquires into objections to recommendations made by the MAAC that the Minister not grant consent to distribute new medicines, and considers appeals regarding clinical trials, sales of medical devices and licence applications.

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 (MHRT) is to consider whether or not 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 is able to apply to the MHRT for a review of his or her condition. The patient can appeal an MHRT decision to the District Court or High Court.

District inspectors for mental health

District inspectors are lawyers appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 to assist people being assessed or treated under it, be it in a psychiatric unit or in the community. The inspectors provide information and ensure the rights of those being assessed and treated are upheld. As such they are independent from the Ministry of Health, but are not patient advocates. District inspectors are also required to be detached from the clinical decision-making processes that affect individual patients and care recipients.

Misuse of Drugs Act 1975

Expert Advisory Committee on Drugs

The Expert Advisory Committee on Drugs (EACD):

- conducts reviews of controlled drugs and other narcotic or psychotropic substances
- recommends to the Minister of Health whether and how such substances should be classified
- increases public awareness of its work by (for instance) releasing papers, reports and recommendations.

New Zealand Public Health and Disability Act 2000

Cancer Control New Zealand (CCNZ)

CCNZ provides an independent, sustainable focus for cancer control, leading the sector to implement the New Zealand Cancer Control Strategy, reduce the incidence and impact of cancer, and reduce inequalities with respect to cancer. CCNZ reports annually to the Minister of Health and may also advise on any other matters the Minister specifies by notice to the Council.

Regional health and disability ethics committees (HDECs)

Regional health and disability ethics committees (HDECs) undertake ethical reviews of proposed health and disability research, and innovative practice. Their primary role is to safeguard the rights, health and wellbeing of consumers and research participants, in particular, those with diminished autonomy. HDECs were established after the 1987 inquiry into the treatment of cervical cancer and other related matters at National Women's Hospital (the Cartwright inquiry), and the 1988 Report on the inquiry. The HDECs are currently being restructured, with changes to take effect 1 July 2012.

National Ethics Advisory Committee (NEAC)

The National Advisory Committee on Health and Disability Support Services Ethics (known as the National Ethics Advisory Committee, or NEAC) is required by statute to advise the Minister of Health on ethical issues of national significance, and to determine nationally consistent ethical standards across the health sector. NEAC is required by its terms of reference to agree its work programme with the Minister of Health.

Radiation Protection Act 1965

Radiation Protection Advisory Council

The Radiation Protection Advisory Council advises the Director-General on applications for licences to use irradiating apparatus and/or radioactive materials. It also advises the Minister of Health in respect of regulations under the Act, the exercise of the Minister of Health's powers, and other matters including those referred to it by the Minister.