Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector
In the foreword to the New Zealand Health Strategy I noted that people had been telling the Government that they wanted a system that put people at its heart. I also noted that higher-quality care had been identified as a common goal for the health system. Quality is also reflected in a number of the objectives in the New Zealand Disability Strategy.

*Improving Quality (IQ): A systems approach for the New Zealand health and disability sector* gives further focus to the importance of quality. It is a commitment to supporting continuous quality improvement by each person who works within the system, by the people cared for and supported by the system, and by the system itself.

We want to put people at the heart of the system, particularly at the interface between those receiving health and disability services and those delivering them.

In this document the term ‘people’ is used in its broadest sense, because there should be both an individual and a population perspective to quality improvement within the health and disability system.

The approach in this document is my response to requirements in the New Zealand Public Health and Disability Act 2000, and to advice I have received from the National Health Committee. The Committee highlighted the importance of taking a systems approach to quality improvement. This is consistent with international developments, such as the work of Dr Don Berwick of the United States Institute for Healthcare Improvement, which have highlighted the importance of such an approach. A systems approach recognises that quality is the result of the complex interaction of people, individuals, teams, organisations and systems.

Quality can always be enhanced even though very good work is already happening. *Improving Quality* reflects this approach by including an ongoing review and updating process.

I am confident that this document will help all health professionals to provide continually improving health services to all New Zealanders.

Hon Annette King
Minister of Health
Acknowledgements

The development of this document has been informed by advice from the members of a working group formed for the project (the members are listed in Appendix 1), by the National Health Committee’s advice in its *Safe Systems Supporting Safe Care* report, by informal feedback from various organisations, and through formal written consultation. All of this advice has been carefully considered, and where possible, incorporated into this document.

The Improving Quality logo

The Improving Quality logo uses the symbol of the koru.

The koru represents the ever-evolving spiral of life within which is embodied the concept of continuous improvement.

It symbolises the hierarchy of growth, knowledge and development that exists within the social institutions of whānau, hapu and iwi.

Within this context there are quality processes for ensuring the transfer of knowledge from one generation to the next.

This can be translated in the health and disability sector to a systems approach that recognises that quality is the cumulative result of the interactions of people, individuals, teams, organisations and systems.

Contact

The Ministry of Health is responsible for co-ordinating and updating this document on an ongoing basis. Quality improvement activities are being co-ordinated through the Clinical Services Directorate. The Deputy Director-General of this directorate is Dr Colin Feek. In the first instance, queries about this document should be forwarded to:

Gillian Bohm
Principal Advisor, Quality Improvement
Clinical Services Directorate
Ministry of Health
PO Box 5013
Wellington
gillian_bohm@moh.govt.nz
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Executive Summary

Many organisations within the health and disability sector, and the people delivering health and disability services, are already undertaking a considerable range of quality-related activities. Many services are of high quality and there is a commitment by many to a culture of ongoing quality improvement. However, this culture can always be strengthened and adopted more widely.

*Improving Quality (IQ): A systems approach for the New Zealand health and disability sector* provides a shared approach and shared language to enable enhanced quality improvement in the New Zealand health and disability system. It is a commitment to supporting continuous quality improvement by each person who works within the system, by people affected by the system, and by the system itself.

The approach in this document is the Minister of Health’s response to advice from the National Health Committee on *Safe Systems Supporting Safe Care*. The approach is also being used to meet the Minister of Health’s obligations in Part 2, Section 9, of the New Zealand Public Health and Disability Act 2000.

**Vision**

Improvements in quality are necessary to support a vision of people in the New Zealand health and disability system receiving people-centred, safe and high-quality services that continually improve and that are culturally competent.

‘People-centred’ means involving people and being receptive and responsive to their needs and values. It includes both individuals and population groups receiving services.

**Systems approach**

A systems approach to quality improvement is necessary. This is because the health and disability system is complex, with decision-making and actions occurring across a range of people, individuals, teams, organisations and subsystems. A systems approach is not an end in itself, but a means to enhance services for the benefit of people, including consumers and their families and whānau.

Within a systems approach, quality can be defined as the degree to which the services for individuals or populations increase the likelihood of desired health outcomes, and/or increase the participation and independence of people with a disability, and are consistent with current professional knowledge (adapted from Lohr 1990). Quality is the cumulative result of the interactions of people, individuals, teams, organisations and systems.
Dimensions of quality

The key dimensions of quality in the health and disability system are:

• people-centred
• access and equity
• safety
• effectiveness
• efficiency.

These dimensions rest on the foundations of the partnership, participation and protection principles of the Treaty of Waitangi.

Quality improvement and quality assurance

Maintaining quality through quality assurance activities, as well as quality improvement, is important. A quality improvement approach includes:

• an explicit concern for quality, vested in teams
• the viewing of quality as the search for continuous improvement
• an emphasis on improving work processes to achieve desired outcomes
• a focus on developing systems and investing in people to achieve high-quality health outcomes (Harvey 1996).

Goals and action plan

Eleven goals are identified to support the vision in this document. The goals are outlined below.

1. There are more effective service outcomes for Māori by acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi and applying the principles of partnership, participation and protection.

2. There is a shared vision towards safe and quality care that is engendered through committed leadership at all levels, which supports constant maintenance and improvement in service quality, and takes into account Māori aspirations and priorities.

3. People are encouraged and supported to participate in the planning, delivery and assessment of health and disability services and programmes, including the active participation of Māori.

4. There is widespread awareness, understanding and commitment to a quality improvement culture at all levels of the health and disability sector.

5. There is evolutionary redesign of systems of care to support delivery of quality services.

6. Unexpected adverse outcomes are managed in an open and supportive manner that builds trust and confidence in the system and is fair to all participants.
7. There is effective and open communication, co-ordination and integration of service activities that recognise the value of teamwork.

8. There is a supportive and motivating environment that provides the workforce with appropriate tools, including cultural competency tools, for continuous learning and ongoing improvement in planning, delivery and assessment of health and disability services.

9. Useful knowledge and information, including Māori satisfaction information and clinical evidence, is readily available and shared to support a quality-conscious culture.

10. Regulatory protections that assure safe care are in place to support people and service providers.

11. The goals in this document and associated actions are reviewed and updated on an ongoing basis.

An action plan has been prepared to support progress towards the goals of *Improving Quality*. Over time this action plan will be updated, and representatives of the health and disability sector will be able to contribute to this.

**Strategy for nationally consistent standards and quality assurance programmes**

Part 2, Section 9, of the New Zealand Health and Disability Act 2000 requires a strategy for the development, use and monitoring of nationally consistent standards and quality assurance programmes. The strategy for the development, use and monitoring of nationally consistent standards and quality assurance programmes involves:

1. reinforcement of key nationwide standards and quality assurance programmes – the Health and Disability Commissioner (Code of the Health and Disability Services Consumers’ Rights) Regulations 1996, the Health Information Privacy Code 1994, the Health and Disability Services (Safety) Act 2001, National Screening Standards and the Health Practitioners Competence Assurance Bill

2. a focus on the standards and quality assurance expectations of DHBs – because DHBs are responsible for funding most health services for New Zealanders and are major providers of health and disability services to New Zealanders

3. the use of advisory committees as a sector-wide quality assurance and improvement mechanism for the health and disability system – these include the National Health Epidemiology and Quality Assurance Advisory Committee (Epiqual) and Mortality Review Committees

4. use of *Improving Quality* (IQ): A systems approach for the New Zealand health and disability sector to guide and plan sector improvements.

The strategy does not impose any new or additional regulatory or legislative requirements.
1 Introduction

Quality is important in the New Zealand health and disability system. It is identified as a cornerstone of a high-performing system in the New Zealand Health Strategy and is an objective of the New Zealand Disability Strategy.

Many organisations within the health and disability sector, and the people delivering health and disability services, are already undertaking a considerable range of quality-related activities. Many services are of high quality and there is a commitment by many services to the ongoing improvement of quality. Some notable examples include:

- accreditation of many health and disability support service providers by a range of accreditation agencies
- implementation of practice standards for primary health care by general practices
- the winning initiatives celebrated at the New Zealand Health Innovation Awards.

While many organisations and individuals within the health and disability sector have already developed a culture of quality improvement, this culture can always be strengthened and adopted more widely. This is true both within those organisations responsible for designing and resourcing the system, and within those delivering health and disability support services. A key feature of a quality improvement culture is the desire to continuously improve the quality of health and disability support services.

*Improving Quality (IQ): A systems approach for the New Zealand health and disability sector* provides a shared approach and shared language to enable enhanced quality improvement in the New Zealand health and disability system. It is a commitment to supporting continuous quality improvement by each person who works within the system, by people affected by the system, and by the system itself.

The approach in this document is the Minister of Health’s response to advice from the National Health Committee in *Safe Systems Supporting Safe Care*. The approach is also being used to meet the Minister of Health’s obligations in Part 2, Section 9, of the New Zealand Public Health and Disability Act 2000.

**Vision**

Improvements in quality are necessary to support a vision of people in the New Zealand health and disability system receiving people-centred, safe and high-quality services that continually improve and that are culturally competent. ‘People-centred’ means involving people and being receptive and responsive to their needs and values. It includes both individuals and population groups receiving services.
Aims

Improving quality is a process that can always be made better even though very good work is already happening. Three aims have been identified to enable ongoing improvements in quality. These aims have been informed by the work of the National Health Committee (2001; 2002) which identified areas of focus for improvement in the system.

The aims are to:

• provide a shared purpose, shared vision and shared language to enable enhanced quality improvement in the New Zealand health and disability system
• enable a systems approach to quality improvement in the New Zealand health and disability system
• enable improved co-ordination of quality improvement activities in the New Zealand health and disability system.

Improving Quality is intended to provide guidance to participants in the system to improve the quality of health and disability service delivery on an ongoing basis. It is intended that its approach will support quality improvement in both public and private providers of health and disability services.

The focus is primarily on the delivery of health and disability services, as opposed to the overall performance of the system. The latter is the subject of the overriding objectives, priorities and principles outlined in the New Zealand Health Strategy and the New Zealand Disability Strategy.

Goals and action plan

Eleven goals are identified in this document that support the vision of people receiving people-centred, safe and high-quality services that continually improve. They are outlined in Chapter 4.

While goals are intended to be enduring, the actions needed to support them will change as improvements are made and priorities evolve. It is hoped that over time both individuals and organisations will give effect to the vision and goals in this document through their quality improvement planning and actions.

An action plan has been prepared to support progress towards the goals in this document. Over time this action plan will be updated, and representatives of the health and disability sector will be able to contribute to this.

Quality improvement and quality assurance

Quality can be defined as the degree to which the services for individuals or populations increase the likelihood of desired health outcomes and/or increase the participation and independence of people with a disability, and are consistent with current professional knowledge (adapted from Lohr 1990). Quality is the cumulative result of the interactions of people, individuals, teams, organisations and systems.
Quality improvement includes continuous quality improvement and quality assurance activities. While both are important, there is growing international evidence indicating that focusing on quality improvement leads to better outcomes than a focus on quality assurance activities alone.

Quality improvement includes:
• an explicit concern for quality, vested in teams
• the viewing of quality as the search for continuous improvement
• an emphasis on improving work processes to achieve desired outcomes
• a focus on developing systems and investing in people to achieve high-quality health outcomes (Harvey 1996).

Maintaining quality through quality assurance activities as well as quality improvement is important. The relationship between quality assurance, quality improvement, goals and actions is illustrated in Figure 1.

**Figure 1:** Relationship between quality assurance and quality improvement

The environment in which quality assurance and quality improvement activities occur has a major impact on their success. The next chapter focuses on the context in which this document has been developed.
2 Context

Culture and environment

Enabling a culture of quality improvement is the best way to enhance quality improvement in the New Zealand health and disability system. Without a supportive culture and environment, the system is less likely to foster the co-operation and transparency of information necessary for successful quality improvement. Quality improvement requires openness and co-operation (Associate Minister of Health 2001).

A commitment to supporting an infrastructure that enables quality improvement is also important. Infrastructure includes information systems that support appropriate sharing of information and learning from it, as well as those tools that people – including consumers, consumers’ families, whānau, individuals, teams and organisations – can use for quality improvement.

A quality improvement culture and infrastructure are mutually reinforcing. A supportive culture and environment encourage the development and use of quality improvement practices. Likewise, the development and use of a quality improvement infrastructure fosters a quality improvement culture.

Creating the right environment is a particular responsibility of those who are leaders and stewards of the health and disability system.

Evidence for quality improvement

Disciplined, well-informed and intelligent application of quality improvement tools can make health services more effective (Taylor 1998). However, international and New Zealand research and evidence into what tools work best is still relatively limited. We need to keep tracking developments in the evidence and to apply the various quality improvement tools in the contexts where they are shown to be effective. There is no ‘quick fix’ or ‘one size fits all’. Attention to many different factors and multiple approaches are needed (Solberg 2000). One of the purposes of this document is, therefore, to set a high-level direction through goals that can enable locally appropriate quality improvement practices to evolve and improve on a continual basis.

Balancing control and autonomy

Getting an appropriate balance between control and autonomy of participants in the system is very important. This is because of the evidence indicating that context is very important to the success of quality improvement initiatives. Too much control may mean that initiatives are mandated in situations where they do not work. Too much autonomy risks a lack of consistency and poor integration.

The balance between control and autonomy also influences the ability of the system to address novel problems and seize new opportunities. This is important because the
adaptability of the system affects the quality and safety of the services delivered within it. It is often unforeseen problems that lead to poor quality outcomes.

Setting an appropriate balance between control and autonomy is also important for motivating participants in the system (Deci et al 1996). Professionalism is an important factor. This is because people are motivated by the need to be valued and respected, to see the results of their actions, and to have some degree of control (Pencheon and Mien Koh 2000). Having a well-motivated workforce, as well as an adequate workforce in place is important if a quality improvement culture is going to be sustained.

The focus of the approach in this document is therefore on enabling the sector to implement initiatives that work in particular contexts by minimising additional constraints to quality improvement. At the same time it enables a degree of consistency across the sector with a shared vision, shared purpose and shared language. The approach does not in itself impose new or additional legislative or regulatory requirements on the sector.

Leadership and teamwork

Leadership at all levels is critical to securing a culture and infrastructure that support quality improvement. The role of leaders with an interest in quality is to support, foster and promote quality improvement approaches. Such approaches recognise quality as vested in teamwork and as a search for continuous improvement towards a goal of excellence, and emphasise improving work processes (adapted from Harvey 1996). To promote such approaches, leaders will need to create a sense of shared purpose, build effective relations and make connections between action and reflection (adapted from Carroll and Edmondson 2002).

Multidisciplinary teamwork is a key aspect of quality improvement and is linked with leadership. Teamwork requires good relationships between all participants. Good relationships, particularly between those delivering and those receiving care and support, are critical to good quality services. Quality improvement tools should therefore include techniques for team-based problem-solving and team-based care (Kizer 2002).

Benefits and costs of quality improvement

Poor quality consumes resources that could be used for more and/or better care at both an individual and a population level. At the individual level resources are consumed through waste, rework and avoidable escalation of issues. This is true at the population level as well, where there is also a cost in terms of foregone opportunities to reduce inequalities in health status between population groups. In this sense the inequalities in health status between Māori and non-Māori are a quality issue. The costs of poor quality are borne by the health and disability sector and by society as a whole.

While improving quality can save resources, the activity of improving quality actually uses resources. In fact, doing more and/or better quality improvement may require a greater share of resources than is currently allocated to this activity. The balance between the costs and benefits of improving quality is at the heart of decisions on what resources should be allocated to quality improvement activities. These decisions are not always straightforward,
given that the benefits of investing in quality improvement sometimes occur well after the investment. Taking a long-term perspective is therefore important.

At some point, additional investment in quality improvement leads to smaller and smaller improvements. The relationship between the cost of undertaking quality improvement and the resulting improvements in quality can be represented on a U-shaped curve. The cost of each increment of additional quality becomes less and less down to a point, at the bottom of the U-shaped curve, as poor quality is reduced. Beyond this point the cost of each additional unit of quality becomes increasingly expensive as services become of higher and higher quality.

Decisions on what resources should be devoted to ongoing improvements are guided by the constraints and values at the time. These decisions should not inhibit ongoing activities to minimise poor quality, where the benefits of additional investment in quality improvement clearly outweigh the costs. All of these decisions have to be balanced within the resources that are available.

**Accreditation, certification and quality improvement**

Two of the key quality improvement tools in use in the New Zealand health and disability system are accreditation and certification.

Accreditation is the process by which organisations demonstrate adherence to specific levels of practice defined by an accreditation agency, often expressed as standards, with the subsequent right to associate themselves with the agency. The practices may cover quality assurance and/or improvement activities. The requirements may include minimum requirements (quality assurance) as well as setting goals for ongoing improvement (quality improvement). Different agencies have a different mix of assurance and improvement in their requirements. Over time, as improvements are made, the accreditation agencies may update their requirements to support further improvements.

Certification is the process by which organisations meet the standards of the Health and Disability Services (Safety) Act 2001. It is a legislative requirement. Standards cover both quality assurance and quality improvement activities. Audit agencies that have been designated by the Director-General of Health will undertake certification audits. The Health and Disability Services (Safety) Act 2001 includes a mechanism for updating the standards under it. One of the objectives of the Act is to encourage health and disability support service providers to continuously improve service quality. Some of the standards also have an improvement focus.

A number of accreditation organisations have aligned some of their requirements with the standards under the Health and Disability Services (Safety) Act 2001.
Complex system

Fundamental to the approach to quality improvement are assumptions about the nature of the New Zealand health and disability system and how it works. It is assumed that the system is a complex, adaptive system. Within this system, quality improvement results from the complex interactions of people, individuals, teams, organisations and systems. The overall system continually adapts to changes within it and responds to changes from outside it.

The complexity of the system is also reflected in perceptions of what constitutes a quality issue. As examples, amputation of the wrong limb, the treatment of people in a disabling manner or delivery of a meal different from that requested are all examples of quality issues. An important aspect of establishing a common approach for the system is the need for participants to value and respond to both technical and people-centred measures of quality.

The systems approach is the focus of the next chapter.
3 A Systems Approach

System levels

This document supports a greater systems approach to quality improvement and improved co-ordination of quality improvement. A systems approach is necessary because the health and disability system is complex, with decision-making and actions happening across a variety of people, organisations and subsystems. A systems approach is not an end in itself but a means to enhance services for the benefit of people, including consumers, their families and whānau. A systems approach recognises that quality is the cumulative result of the interactions of people, individuals, teams, organisations and systems.

Quality improvement needs to encapsulate all levels of the system and the interactions between them. The levels are shown diagrammatically in Figure 2. They range from the overall system, through the organisations and teams and individuals within those organisations, to the people receiving and affected by the services delivered in the system.

It is recognised that the health and disability sector exists within, and interacts with, wider systems and other sectors. For simplicity this wider environment has not been shown diagrammatically. It is nevertheless very important given the contribution of other sectors to improved health outcomes, and the participation and independence of people with a disability.

People are at the heart of quality in the New Zealand health and disability system. The people include consumers as well as their families and whānau. They also include both individuals and population groups receiving services.

Figure 2: Quality dimensions for the New Zealand health and disability system

IQ: A Systems Approach for the New Zealand Health and Disability Sector
In the past, some individuals have been identified as being responsible for poor quality in instances where systems and not individuals have been the real cause. While a greater focus on systems is required, this should not be at the cost of removing responsibility from professionals, particularly in instances where behaviour has been unacceptable. Professionalism is an important factor in quality in the health and disability system.

Quality dimensions

The partnership, participation and protection principles of the Treaty of Waitangi are the foundations of quality assurance and quality improvement in the New Zealand health and disability sector. Built upon these foundations are the key quality dimensions of people-centred, access and equity, safety, effectiveness and efficiency. The dimensions are shown in Figure 2 as ‘slices’ through semicircles representing the different levels of the system, with the focus on people. Improving quality requires balancing across the dimensions. It also requires recognising the contributions and interactions across all levels of the system.

The dimensions of equity and access are particularly relevant to Māori health. This is because in the past concerns about quality have often focused on technical safety and effectiveness, not on access and equity. The failure of health and disability services to reach Māori as effectively as non-Māori is a quality issue.

Inequalities in health status for different population groups (eg, between the health status of Pacific and non-Pacific peoples) is also a quality issue when they result from poor access to services and/or inappropriate service delivery. While the equity and access dimensions probably most directly relate to inequalities, other dimensions may also be important. For example, services are most likely to be effective if delivered in a culturally competent manner.

Cultural competency can be defined as the ability to integrate different cultural perspectives and respond appropriately to the cultural needs of individuals (National Health Committee 2002). It applies at all levels of the system, and includes individuals, teams, organisations and the overall system. It is not just the responsibility of those directly involved in the delivery of health and disability support services.

Definitions for the foundations of the partnership, participation and protection principles of the Treaty of Waitangi, and for each of the quality dimensions, are provided in Table 1.
Table 1: Foundation principles and definitions of the quality dimensions in the New Zealand health and disability system

<table>
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<th>Foundation principles</th>
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<tr>
<td>• <strong>Partnership</strong> is the principle of working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.</td>
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<tr>
<td>• <strong>Participation</strong> is the principle of involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services.</td>
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<tr>
<td>• <strong>Protection</strong> is the principle of working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.</td>
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<th>Quality dimensions</th>
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<tr>
<td>• <strong>People-centred</strong> is the extent to which a service involves people, including consumers, their families and whānau, and is receptive and responsive to their needs and values. It includes participation, appropriateness, adherence to the Code of the Health and Disability Services Consumers’ Rights 1996¹ and adherence to other consumer protections such as the Health Information Privacy Code 1994.</td>
</tr>
<tr>
<td>• <strong>Equity and access</strong> is the extent to which people are able to receive a service on the basis of need and likely benefit, irrespective of factors such as ethnicity, age, impairment or gender. It includes the physical environment, and the extent to which this is a barrier to accessing health and disability support services. Being able to physically access health and disability support service facilities can be a significant issue for people with disabilities.</td>
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<tr>
<td>• <strong>Safety</strong> is the extent to which harm is kept to a minimum.</td>
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<tr>
<td>• <strong>Efficiency</strong> is the extent to which a service gives the greatest possible benefit for the resources used.</td>
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<tr>
<td>• <strong>Effectiveness</strong> is the extent to which a service achieves an expected and measurable benefit.</td>
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¹ The Health and Disability Commissioner (Code of the Health and Disability Services Consumers’ Rights) Regulations 1996 is a regulation under the Health and Disability Commissioner Act 1994. When consumers believe that they have not received services in accordance with the Code, they can complain to the Health and Disability Commissioner.
Balancing the dimensions

For any given situation, dimensions of quality will need to be balanced against each other taking into account the values and circumstances. At all times, however, balancing decisions need to recognise that people-centredness is at the heart of quality in service delivery.

Balancing decisions by their nature involve judgements informed by the values of the people and organisations making those judgements. Values differ across individuals, populations, cultures and organisations. The approach adopted in this document is intended to enable the application of different value sets when balancing across the dimensions of quality.

Goals have been identified that enable a systems approach to quality improvement. They are the focus of the next chapter.
4 Quality Improvement Goals

Goals

Eleven goals have been identified that support quality improvement in the New Zealand health and disability sector. These are a high-level statement of what is needed in order to deliver on the quality improvement vision and aims. Development of the goals was informed by the National Health Committee’s advice (2001; 2002) and by a working group established to provide advice to the Ministry of Health (members of which are listed in Appendix 1).

The goals and their relationship to the vision and aims are outlined in Table 2.
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<td><strong>Vision:</strong> People in the New Zealand health and disability system receive people-centred, safe and high-quality services that continually improve and that are culturally competent.</td>
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<th>Aims</th>
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<td>Provide a shared purpose, shared vision and shared language to enable enhanced quality improvement in the New Zealand health and disability system.</td>
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<td>Enable a systems approach to quality improvement in the New Zealand health and disability system.</td>
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<tr>
<td>Enable improved co-ordination of quality improvement activities in the New Zealand health and disability system.</td>
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<table>
<thead>
<tr>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a shared vision towards safe and quality care that is engendered through committed leadership at all levels, which supports constant maintenance and improvement in service quality, and takes into account Māori aspirations and priorities.</td>
</tr>
<tr>
<td>People are encouraged and supported to participate in the planning, delivery and assessment of health and disability services and programmes, including the active participation of Māori.</td>
</tr>
<tr>
<td>There is widespread awareness, understanding and commitment to a quality improvement culture at all levels of the health and disability sector.</td>
</tr>
<tr>
<td>There is evolutionary redesign of systems of care to support delivery of quality services.</td>
</tr>
<tr>
<td>Unexpected adverse outcomes are managed in an open and supportive manner that builds trust and confidence in the system and is fair to all participants.</td>
</tr>
<tr>
<td>There is effective and open communication, co-ordination and integration of service activities that recognise the value of teamwork.</td>
</tr>
<tr>
<td>There is a supportive and motivating environment that provides the workforce with appropriate tools, including cultural competency tools, for continuous learning and ongoing improvement in planning, delivery and assessment of health and disability services.</td>
</tr>
<tr>
<td>Useful knowledge and information, including Māori satisfaction information and clinical evidence, is readily available and shared to support a quality-conscious culture.</td>
</tr>
<tr>
<td>Regulatory protections that assure safe care are in place to support people and service providers.</td>
</tr>
</tbody>
</table>

There are more effective service outcomes for Māori by acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi and applying the principles of partnership, participation, and protection. These principles underlie the vision, aims and goals.

The goals in this document and associated actions are reviewed and updated on an ongoing basis.
Description

To assist the tracking of progress towards the achievement of each goal, a description of how the health and disability system might look when each is achieved has been developed. This description could be translated into indicators if required. However, it is the goal-setting purpose of the description that is important for continuous improvement. The goals and their associated descriptions are outlined in Table 3.
### Table 3: Goals and descriptions

<table>
<thead>
<tr>
<th><strong>Goal:</strong> There are more effective service outcomes for Māori by acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi and applying the principles of partnership, participation and protection.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>• Whānau receive timely, high-quality, effective and culturally appropriate health and disability services to improve whānau ora and reduce inequalities – effective care includes culturally competent service delivery.</td>
</tr>
<tr>
<td>• There are mechanisms for ensuring that Māori aspirations and priorities for health are taken into account in the planning and delivery of services.</td>
</tr>
<tr>
<td>• There is active participation by Māori at all levels of the health and disability sector in decision-making, planning, development and delivery of health services.</td>
</tr>
<tr>
<td>• District Health Boards (DHBs) involve Māori in their decision-making, and service delivery supports effective Māori development.</td>
</tr>
<tr>
<td>• DHBs have addressed the access barriers that exist for many Māori in gaining access to appropriate and accessible services.</td>
</tr>
<tr>
<td>• Māori models of health and traditional healing are recognised and valued.</td>
</tr>
<tr>
<td>• There is improvement in the effectiveness of mainstream services for Māori.</td>
</tr>
<tr>
<td>• DHBs, providers and public health agencies have established processes to gather information on Māori consumer/client/family and whānau satisfaction, clinical pathways and decision-making processes, and organisational capacity and capability.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Goal:</strong> There is a shared vision towards safe and quality care that is engendered through committed leadership at all levels, which supports constant maintenance and improvement in service quality, and takes into account Māori aspirations and priorities.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>• Leadership at all levels of the system supports and promotes a shared quality improvement vision.</td>
</tr>
<tr>
<td>• Leadership at all levels of the system ensures there is co-ordination of quality improvement activities throughout the system so that gaps and inappropriate duplication in activities are minimised.</td>
</tr>
<tr>
<td>• Māori aspirations and priorities are taken into account in the shared quality improvement vision.</td>
</tr>
<tr>
<td>Table 3: Goals and descriptions (continued)</td>
</tr>
<tr>
<td>--------------------------------------------</td>
</tr>
</tbody>
</table>

| **Goal:** People are encouraged and supported to participate in the planning, delivery and assessment of health and disability services and programmes, including the active participation of Māori. |
| Description: |
| • There is active participation of Māori in the planning, delivery and assessment of health and disability services and programmes. |
| • There is active involvement of consumers/clients/families and whānau and communities to ensure the health and disability system is people-centred. |
| • Decision-making processes at all levels of the health and disability system recognise the importance of people and community participation. |
| • Mechanisms are available to support the participation of people in decision-making. |
| • Disabled people are encouraged to take part in decision-making as service users, as staff in the delivery of services, and in the governance, management, planning and evaluation within all services that disabled people use. |

| **Goal:** There is widespread awareness, understanding and commitment to a quality improvement culture at all levels of the health and disability sector. |
| Description: |
| • There is a widespread ethic of quality improvement and the use of quality improvement practices. |
| • Quality improvement is an integral part of care and support processes and there is widespread understanding of it. |
| • There are effective relationships based on mutual trust and respect among all participants in the care process and its ongoing improvement. |
| • Innovation is valued, facilitated and assured throughout the system. |
| • Tensions are dealt with in an open and fair manner. |

| **Goal:** There is evolutionary redesign of systems of care to support delivery of quality services. |
| Description: |
| • There are widespread systems for analysing events, learning and promoting the redesign of systems of care. |
| • There is customisation of systems of care based on people’s needs and values. |
| • Care and support is provided in the most appropriate place for people’s needs. |
| • There is easy and timely access to health and disability services. |
| • There is integration of services across a continuum of care. |
### Table 3: Goals and descriptions (continued)

<table>
<thead>
<tr>
<th>Goal: Unexpected adverse outcomes are managed in an open and supportive manner that builds trust and confidence in the system and is fair to all participants.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>• Adverse events are minimised to the greatest extent possible.</td>
</tr>
<tr>
<td>• When unexpected adverse events occur, all participants believe there is appropriate acknowledgement, explanation and demonstration that steps have been taken to reduce the probability of the event happening again.</td>
</tr>
<tr>
<td>• Learning from adverse events is promoted and encouraged.</td>
</tr>
<tr>
<td>• When injury does occur, systems are in place to make appropriate responses to people’s needs.</td>
</tr>
<tr>
<td>• Individuals are not inappropriately held responsible in instances where the system has led to an adverse event.</td>
</tr>
<tr>
<td>• There is a just culture with an atmosphere of trust and clear lines between acceptable and unacceptable behaviours.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal: There is effective and open communication, co-ordination and integration of service activities that recognise the value of teamwork.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>• Communication with people, across teams, within organisations and system-wide is excellent.</td>
</tr>
<tr>
<td>• Teamwork is widely valued throughout care systems.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal: There is a supportive and motivating environment that provides the workforce with appropriate tools, including cultural competency tools, for continuous learning and ongoing improvement in planning, delivery and assessment of health and disability services.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>• There are relationships based on trust and mutually responsible behaviour.</td>
</tr>
<tr>
<td>• There is ongoing pursuit of competence and education focused on safety and quality across the health and disability support workforce.</td>
</tr>
<tr>
<td>• Cultural competency tools are available to support the health and disability support workforce.</td>
</tr>
<tr>
<td>• Participants are empowered to make positive change rather than feeling helpless and isolated.</td>
</tr>
<tr>
<td>• Infrastructure is in place to enhance performance, learn from experience and deal fairly with failure.</td>
</tr>
<tr>
<td>• Management systems support people so that they do not operate in isolation.</td>
</tr>
<tr>
<td>• Health professionals are supported to be responsive to the needs of disabled people.</td>
</tr>
</tbody>
</table>
Table 3:  Goals and descriptions (continued)

<table>
<thead>
<tr>
<th>Goal: Useful knowledge and information, including Māori satisfaction information and clinical evidence, is readily available and shared to support a quality-conscious culture.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>• Knowledge and information is shared easily, but appropriately, throughout the sector with people, between health and disability workers, between organisations, and among government agencies to assure optimum monitoring and planning.</td>
</tr>
<tr>
<td>• Information on Māori consumer/client/family and whānau satisfaction is available.</td>
</tr>
<tr>
<td>• Evidence, including appropriate clinical evidence* where it exists, is used to inform decision-making at all levels of the system.</td>
</tr>
<tr>
<td>• Effective reporting systems that enable all participants to report events to facilitate learning and adjustment are in place.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal: Regulatory protections that assure safe care are in place to support people and service providers.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>• Effective protection is in place to protect consumers’ and clients’ rights.</td>
</tr>
<tr>
<td>• Effective privacy protection is in place.</td>
</tr>
<tr>
<td>• Effective protection is in place to ensure that health and disability service facilities and the practices undertaken in them are safe.</td>
</tr>
<tr>
<td>• Effective protection is in place to ensure that those delivering health and disability services are competent to do so.</td>
</tr>
<tr>
<td>• Effective protection is in place to ensure medicines and therapeutic devices are safe for those who use or receive them.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal: The goals in this document and associated actions are reviewed and updated on an ongoing basis.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>• There is an annual stocktake by the Ministry of Health of progress in implementing the actions. The actions are updated at least once every three years, with sector input.</td>
</tr>
<tr>
<td>• The goals are updated in any given year if updating of them is identified as a key quality improvement action for that year.</td>
</tr>
</tbody>
</table>

* ‘Evidence’ is used here in a generic sense and does not imply any specific type or level of evidence.
**Action plan**

While goals are intended to be enduring, the actions needed to support them will change as improvements are made and priorities change. An action plan has been prepared to support the quality improvement approach in this document. Actions have been identified in relation to each of the goals outlined above. In the first action plan some of the actions have been sourced from other documents, including Whakatātaka: Māori Health Action Plan 2002–2005, and The Pacific Health and Disability Action Plan. Some of the actions also directly support the approach in The Primary Health Care Strategy and The Health of Older People Strategy. Over time the action plan will be updated. The criteria for including actions in the action plan are documented in the plan itself. The health and disability sector will be involved in updating the action plan.
5 Nationally Consistent Standards and Quality Assurance Programmes

Quality assurance

Setting expectations (standards), their implementation, and measurement of performance against them (quality assurance programmes) are integral components of a quality assurance approach.

Part 2, Section 9, of the New Zealand Health and Disability Act 2000 (the Act) focuses on quality assurance. It requires that the Minister of Health determines a strategy for the development and use of:

• nationally consistent standards and quality assurance programmes for health services and consumer safety
• nationally consistent performance monitoring of health services and consumer safety against those standards and programmes.

A large number of quality assurance mechanisms are in place in the health and disability system. Many of these result from the decisions of individuals and organisations within the system to use these mechanisms. Some of the mechanisms are required by legislation, regulation and/or by funders of public health services. These tend to have a safety focus because health and disability services cannot be considered of high quality unless they are safe (Walshe and Freeman 2002). Some of the mechanisms are used on a nationwide basis.

Given the requirements of Part 2, Section 9, of the Act the focus of this chapter is on key quality assurance mechanisms that are nationally consistent, mainly by way of legislation or regulation given the nationwide jurisdiction these give. To some extent, the existence of a legislative or regulatory assurance mechanism reflects the level of risk and, therefore, the assurance required with some services. The existence of a legislative or regulatory assurance mechanism does not diminish the importance of the other quality assurance and improvement activities in the sector, including some that may have a nationwide focus.

It is the combination of the mechanisms outlined in this chapter and the wide range of other assurance and improvement mechanisms used within the health and disability sector that assure the quality of health and disability services. The need for nationally consistent standards and quality assurance programmes may be reduced by the presence of other effective quality improvement processes.

It is important to recognise that some of the quality assurance mechanisms outlined in this chapter also have a quality improvement dimension. This is because they enable the updating of the standards within them and/or because some of the standards within them have an improvement focus.
Legislation and regulations

A wide range of legislation and associated regulations apply to the health and disability system. These are outlined in Appendix 3. In the broadest sense these can be considered as defining the scope of quality assurance mechanisms in the system.

The health and disability sector is also bound by a range of generic legislation, including the Injury Prevention, Rehabilitation, and Compensation Act 2001, the Privacy Act 1993 and the Health and Safety in Employment Act 1992.

Strategy for nationally consistent standards and quality assurance programmes

The strategy for the development, use and monitoring of nationally consistent standards and quality assurance programmes involves:

• reinforcement of key nationwide standards and quality assurance programmes – the Health and Disability Commissioner (Code of the Health and Disability Services Consumers’ Rights) Regulations 1996, the Health Information Privacy Code 1994, the Health and Disability Services (Safety) Act 2001, National Screening Standards, and the Health Practitioners Competence Assurance Bill

• a focus on the standards and quality assurance expectations of DHBs – because DHBs are responsible for funding most health services for New Zealanders, and are major providers of health and disability services to New Zealanders

• the use of advisory committees as a sector-wide quality assurance and improvement mechanism for the health and disability system – these include the National Health Epidemiology and Quality Assurance Advisory Committee (Epiqual) and Mortality Review Committees

• use of Improving Quality (IQ): A systems approach for the New Zealand health and disability sector to guide and plan sector improvements.

The specific elements that make up each of the components of the strategy and the associated monitoring arrangements are summarised in Table 4. A fuller description of each of the elements is provided in Appendix 2. It is important to recognise, that despite the nationwide focus of the specific elements, some of them do not apply to all types of health and disability provider.

The strategy does not impose any new or additional regulatory or legislative requirements.

Reporting progress

Each year the Minister of Health will report to the House of Representatives on progress in implementing the strategy outlined above. This is to meet the reporting requirements of Part 2, Section 9, of the New Zealand Public Health and Disability Act 2000. Where at all practical, existing monitoring and reporting arrangements will be used to inform the Minister of Health’s reporting to the House of Representatives. This is so that unnecessary additional reporting requirements are not imposed on organisations and individuals within the health and disability sector.
The Minister will also present to the House of Representatives copies of any reports from the National Health Epidemiology and Quality Assurance Advisory Committee and Mortality Review Committees that are covered by Part 2, Sections 17(8) and 18(4), of the Act.

The House of Representatives also receives reports on the quality of health and disability services as part of other reporting arrangements. These include annual reporting by the Minister of Health against progress in implementing the New Zealand Health Strategy, annual reporting by the Minister for Disability Issues against progress in implementing the New Zealand Disability Strategy, and reporting by the Director-General of Health on the current state of public health.
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Element</th>
<th>Level of focus and application</th>
<th>Development and use of standards and quality assurance programmes</th>
<th>Monitoring of standards quality assurance programmes</th>
<th>Improvement mechanism</th>
</tr>
</thead>
</table>
Table 4: Strategy for development, use and monitoring of nationally consistent standards and quality assurance programmes (continued)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Element</th>
<th>Level of focus and application</th>
<th>Development and use of standards and quality assurance programmes</th>
<th>Monitoring of standards quality assurance programmes</th>
<th>Improvement mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Disability Services (Safety) Act 2001.</td>
<td>Organisations. Applies to providers of hospital, rest-home and residential disability care services. The provisions in the Act enable it to be applied to other types of health and disability support service providers.</td>
<td>Provisions of the Act enable additional standards to be developed. From October 2004 all providers covered by standards under the Act must comply with the generic Health and Disability Sector Standards (NZS 8134:2001 – covering consumer rights, organisational management, pre-entry and entry to services, service delivery, managing service delivery, and safe and appropriate environments). Additionally, providers of hospital services, rest-homes and residential disability services must meet Infection Control Standard (NZS 8142:2000), Restraint Minimisation and Safe Practice Standard (NZS 8141:2001), and National Mental Health Sector Standards (NZS 8143:2001) to receive certification under the Act.</td>
<td>Audit, monitoring and certification arrangements as outlined in the Act.</td>
<td>Standards review mechanism as outlined in section 24 of the Act.</td>
<td></td>
</tr>
</tbody>
</table>
Table 4: Strategy for development, use and monitoring of nationally consistent standards and quality assurance programmes (continued)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Element</th>
<th>Level of focus and application</th>
<th>Development and use of standards and quality assurance programmes</th>
<th>Monitoring of standards quality assurance programmes</th>
<th>Improvement mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Practitioners Competence Assurance Bill.</td>
<td>Individuals.</td>
<td>Applies to health practitioners.</td>
<td>Outlined in the provisions of the Act when the Act is passed.</td>
<td>Outlined in the provisions of the Act when the Act is passed. Registration of health professionals in accordance with the Act will be undertaken by the various registration bodies such as the New Zealand Medical Council and the New Zealand Nursing Council.</td>
<td>Mechanisms as outlined in Part 3 of the Bill, assuming these are reflected in the final Act.</td>
</tr>
</tbody>
</table>
Table 4: Strategy for development, use and monitoring of nationally consistent standards and quality assurance programmes (continued)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Element</th>
<th>Level of focus and application</th>
<th>Development and use of standards and quality assurance programmes</th>
<th>Monitoring of standards quality assurance programmes</th>
<th>Improvement mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on the expectations of DHBs through the appropriate planning and accountability documentation</td>
<td>DHB Indicator Framework, Service Cover, and Operational Policy Framework documents.</td>
<td>Organisations. Applies to DHB funder and provider divisions. DHB funding divisions may reflect some of the requirements in service agreements with providers of health and disability support services.</td>
<td>Quality and safety requirements outlined in the Service Cover and Operational Policy Framework documents.</td>
<td>Quarterly monitoring by the Ministry of Health of DHB performance. Monitoring of provider performance by DHBs.</td>
<td>Annual updating of DHB Indicator Framework, Service Cover, and Operational Policy Framework documents</td>
</tr>
</tbody>
</table>
6 Conclusion

This document has outlined steps to enable people in the New Zealand health and disability system to receive people-centred, safe and high-quality services that continually improve. It aims to:

• provide a shared purpose, shared vision and shared language to enable enhanced quality improvement in the New Zealand health and disability system

• enable a systems approach to quality improvement in the New Zealand health and disability system while recognising that a systems approach is not an end in itself, but a means to enhance services for the benefit of people, including consumers, their families, and whānau

• enable improved co-ordination of quality improvement activities in the New Zealand health and disability system.

The document will be updated using a quality improvement approach. The updating process will involve sector input. The aims, goals and nationally consistent standards and quality assurance programmes will be updated when required. Progress in giving effect to the approach in the document will be reported annually to the House of Representatives by the Minister of Health.

Improving quality requires constant attention and effort. It is a process that can always be made better even though very good work is already happening. It is the responsibility of all the people, individuals, teams, organisations and systems within the health and disability system. The purpose, vision, aims and goals outlined in this document are intended to enable all the participants to make ongoing improvements to the quality of health and disability support services for New Zealanders.
accreditation  The process by which organisations demonstrate adherence to specific levels of practice defined by an accreditation agency, often expressed as standards, with the subsequent right to associate themselves with the agency. The practices may cover quality assurance and/or improvement activities.

certification  The process by which organisations meet the standards of the Health and Disability Services (Safety) Act 2001. It is a legislative requirement. Standards cover both quality assurance and quality improvement activities. Audit agencies that have been designated by the Director-General of Health will undertake certification audits.

cultural competency  The ability to integrate different cultural perspectives and respond appropriately to the cultural needs of individuals (National Health Committee 2002).

effectiveness  The extent to which a service achieves an expected and measurable benefit.

efficiency  The extent to which a service gives the greatest possible benefit for the resources used.

equity and access  The extent to which people are able to receive a service on the basis of need and likely benefit irrespective of factors such as ethnicity, age, impairment or gender. It includes the physical environment, and the extent to which this is a barrier to accessing health and disability support services. Being able to physically access health and disability support service facilities can be a significant issue for people with disabilities.

participation  The principle of involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services.

partnership  The principle of working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.

people-centred  The extent to which a service involves people, including consumers and their families and whānau, and is receptive and responsive to their needs and values. It includes participation, appropriateness, adherence to the Health and Disability Commissioner (Code of the Health and Disability Services Consumers’ Rights) Regulations 1996 and adherence to other consumer protections such as the Health Information Privacy Code 1994.
| **protection** | The principle of working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices. |
| **quality** | The degree to which the services for individuals or populations increase the likelihood of desired health outcomes, and/or increase the participation and independence of people with a disability, and are consistent with current professional knowledge (adapted from Lohr 1990). |
| **quality assurance** | The detection of problems through external or internal inspection, and their correction through systematic activity (National Health Committee 2001). |
| **quality improvement** | An explicit concern for quality vested in teamwork, as a search for continuous improvement towards a goal of excellence, with an emphasis on improving work processes, and through developing systems and investing in people to achieve quality (adapted from Harvey 1996). |
| **safety** | The extent to which harm is kept to a minimum. |
Appendix 1: Working Group Members

A working group was formed specifically for the purpose of providing advice to inform development of this document. The working group met on three occasions. The people who participated in one or more of these meetings were:

Geoff Annals (New Zealand Nurses Organisation)
Audrey Aumua (Chief Advisor, Pacific, Ministry of Health)
Deborah Baird (Māori Health Directorate, Ministry of Health)
Gillian Bohm (Ministry of Health)
Robin Briant
Cathy Cooney (District Health Boards New Zealand Chief Executive Representative)
Barbara Crawford (Waikato DHB, member of DHB Quality Managers’ Group)
Elaine Elbe (ACC)
Maureen Gillon (Royal New Zealand College of General Practitioners)
Peter Gow (Counties-Manukau District Health Board)
Gillian Grew (Ministry of Health)
Andrew Holmes (Ministry of Health)
Peter Jansen
Elizabeth Knopf (Ministry of Health)
Sally McLean (District Health Boards New Zealand)
Sue Merrilees (Disability Issues Directorate, Ministry of Health)
Simon O’Dowd (Residential Care Association)
Dale Oliff (Southland District Health Board)
Lesley Orr (Disability Consumer Representative)
David Press (Ministry of Health)
Simon Robb (Ministry of Health)
Peter Roberts (Ministry of Health)
Christine Roseveare (Te Wana Programme, Health Care Aotearoa)
Alan Shirley (Wairarapa DHB, member of Senior Medical Advisors’ Group)
Judi Stridd (Women’s Health Action)
Chris Tuffnell (Spot On Quality)
Jim Vause (Royal New Zealand College of General Practitioners).
Appendix 2: Strategy for Nationally Consistent Standards and Quality Assurance Programmes

A strategy for the development, use and monitoring of nationally consistent standards and quality assurance programmes was outlined in Chapter 5. It involves:

- reinforcement of key nationwide standards and quality assurance programmes – Code of Health and Disability Services Consumers’ Rights 1996, the Health Information Privacy Code 1994, the Health and Disability Services (Safety) Act 2001, National Screening Standards, and the Health Practitioners Competence Assurance Bill

- a focus on the standards and quality assurance expectations of DHBs – because DHBs are responsible for funding most health services for New Zealanders, and they are also major providers of health and disability services to New Zealanders

- the use of advisory committees as a sector-wide quality assurance and improvement mechanism for the health and disability system – these include the National Health Epidemiology and Quality Assurance Advisory Committee (Epiqual) and Mortality Review Committees

- use of Improving Quality (IQ): A systems approach for the New Zealand health and disability sector to guide and plan sector improvements.

A fuller description of each of these elements is provided below.

Key standards and quality assurance mechanisms

The key quality assurance mechanisms and requirements in the New Zealand health and disability system are as follows.

i) Code of Health and Disability Services Consumers’ Rights

The Code is set out in the Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996. It includes a complaints mechanism.

The rights of consumers and the duties of providers under the Code are as follows:

Right 1 – Right to be treated with respect

(1) Every consumer has the right to be treated with respect.

(2) Every consumer has the right to have his or her privacy respected.

(3) Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori.
Right 2 – Right to freedom from discrimination, coercion, harassment, and exploitation
Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial, or other exploitation.

Right 3 – Right to dignity and independence
Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

Right 4 – Right to services of an appropriate standard
(1) Every consumer has the right to have services provided with reasonable care and skill.
(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Right 5 – Right to effective communication
(1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.
(2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

Right 6 – Right to be fully informed
(1) Every consumer has the right to the information that a reasonable consumer, in that consumer’s circumstances, would expect to receive, including –
   (a) an explanation of his or her condition; and
   (b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
   (c) advice of the estimated time within which the services will be provided; and
   (d) notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
   (e) any other information required by legal, professional, ethical, and other relevant standards; and
   (f) the results of tests; and
   (g) the results of procedures.
(2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer’s circumstances, needs to make an informed choice or give informed consent.
(3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about –
   (a) the identity and qualifications of the provider; and
   (b) the recommendation of the provider; and
   (c) how to obtain an opinion from another provider; and
   (d) the results of research.

(4) Every consumer has the right to receive, on request, a written summary of information provided.

Right 7 – Right to make an informed choice and give informed consent

(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

(2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.

(3) Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.

(4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where –
   (a) it is in the best interests of the consumer; and
   (b) reasonable steps have been taken to ascertain the views of the consumer; and
   (c) either –
      (i) if the consumer’s views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or
      (ii) if the consumer’s views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

(5) Every consumer may use an advance directive in accordance with the common law.

(6) Where informed consent to a health care procedure is required, it must be in writing if –
   (a) the consumer is to participate in any research; or
   (b) the procedure is experimental; or
   (c) the consumer will be under general anaesthetic; or
   (d) there is a significant risk of adverse effects on the consumer.

(7) Every consumer has the right to refuse services and to withdraw consent to services.
Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable.

Every consumer has the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health care procedure.

Any body parts or bodily substances removed or obtained in the course of a health care procedure may be stored, preserved, or utilised only with the informed consent of the consumer.

Right 8 – Right to support
Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer’s rights may be unreasonably infringed.

Right 9 – Rights in respect of teaching or research
The rights in this Code extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching or research.

Right 10 – Right to complain
(1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.

(2) Every consumer may make a complaint to –
(a) the individual or individuals who provided the services complained of; and
(b) any person authorised to receive complaints about that provider; and
(c) any other appropriate person, including –
   (i) an independent advocate provided under the Health and Disability Commissioner Act 1994
   (ii) the Health and Disability Commissioner.

(3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

(4) Every provider must inform a consumer about progress on the consumer’s complaint at intervals of not more than one month.

(5) Every provider must comply with all the other relevant rights in this Code when dealing with complaints.

(6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that –
   (a) the complaint is acknowledged in writing within five working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and
   (b) the consumer is informed of any relevant internal and external complaints procedures, including the availability of –
      (i) independent advocates provided under the Health and Disability Commissioner Act 1994
(ii) the Health and Disability Commissioner; and

(c) the consumer’s complaint and the actions of the provider regarding that complaint are documented; and

(d) the consumer receives all information held by the provider that is or may be relevant to the complaint.

(7) Within 10 working days of giving written acknowledgement of a complaint, the provider must –

(a) decide whether the provider –

   (i) accepts that the complaint is justified; or

   (ii) does not accept that the complaint is justified; or

(b) if it decides that more time is needed to investigate the complaint –

   (i) determine how much additional time is needed; and

   (ii) if that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.

(8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of –

(a) the reasons for the decision; and

(b) any actions the provider proposes to take; and

(c) any appeal procedure the provider has in place.

ii) Health Information Privacy Code 1994

The Code sets out a number of rules relating to the collection, storage and use of health information. It also includes a complaints mechanism. The rules relate to the:

• Rule 1: Purpose of collection of health information

• Rule 2: Source of health information

• Rule 3: Collection of health information from individual

• Rule 4: Manner of collection of health information

• Rule 5: Storage and security of health information

• Rule 6: Access to personal health information

• Rule 7: Correction of health information

• Rule 8: Accuracy etc of health information to be checked before use

• Rule 9: Retention of health information

• Rule 10: Limits on use of health information

• Rule 11: Limits on disclosure of health information

• Rule 12: Unique identifiers.
iii) The Health and Disability Services (Safety) Act 2001

A new framework for improved safety standards in our hospitals, rest homes and in residential homes for people with disabilities was introduced with the passing of the Health and Disability Services (Safety) Act 2001 (the Safety Act). The objectives of the Safety Act are to:

- promote safe health and disability services
- establish consistent and reasonable standards for health and disability services
- encourage health and disability providers to take responsibility for safely providing services
- encourage health and disability providers to continuously improve service quality.

The Safety Act provides for consistently safe, high-quality services for consumers from more than 3000 health and disability service providers, while also replacing fragmented, outdated legislation. Medical, surgical, paediatric, maternity, age-related, mental health, and intellectual and disability services (including residential mental health homes and homes for people with disabilities) are all covered by the Safety Act.

From 1 October 2002 there is a two-year transition period to allow existing licensed providers time to meet the Safety Act’s requirements and become certified. By 1 October 2004 the new Act will repeal the Hospitals Act 1957 and sections of the Disabled Persons Community Welfare Act 1975, and it will revoke the Hospitals Regulations 1993, the Old People’s Homes Regulations 1987, and the Obstetric Regulations 1986. Also by 1 October 2004 all providers of hospitals, rest-homes and residential disability services must be certified under the Safety Act. From 1 October 2002 all providers were required to be certified under the Safety Act prior to commencing the provision of services.

Standards

The Health and Disability Sector Standards (NZS 8134:2001) are the generic standard of the new legislation. They set an agreed level for minimum safety and encourage quality improvement in six key areas:

- consumer rights
- organisational management
- pre-entry and entry to services
- service delivery
- managing service delivery
- safe and appropriate environments.

A further set of safety standards has been developed for use with the Safety Act. Providers of hospital services, rest homes and residential disability services must meet these new standards to be certified. The health and disability standards were developed by the sector for the sector, after wide-ranging industry and public consultation. Obtaining sector support and consumer input has been crucial to their development.
The new Safety Standards cover specific aspects of services and include:

- Infection Control (NZS 8142:2000)
- Restraint Minimisation and Safe Practice (NZS 8141:2001)

The health and disability standards provide a mechanism for continuous development of quality improvement systems and will be reviewed regularly to ensure they keep up with changes in service delivery. The Minister of Health will have the power to approve more standards from time to time.

**Inputs to outcomes**

The Safety Act and health and disability standards move the focus towards monitoring the outcomes of service delivery, and the quality and safety of care provided, rather than inputs. The current licensing and registration system focuses on inputs, or the requirements needed to provide a service, but in New Zealand and overseas we now recognise that a list of what must be provided (a prescription of inputs) does not necessarily give good results or outcomes.

For example, the Old People’s Homes Regulations 1987 prescribe ratios of toilets and baths to residents. This prescription, although important, does not address types of issues such as privacy and independence now included in the standards. Under the new legislation providers must show evidence that services are managed by suitably qualified or experienced people, and that they can safely meet the needs of people in their care.

**Auditing**

Providers will be audited by independent designated audit agencies, ensuring providers are safe, outcome focused and continuously improving service quality. Providers will receive certification usually for three years, but maybe only for one or two years. Providers who demonstrate safety and continual service improvement may get certification for more than three years, up to a maximum of five years.

Audit agencies will have to demonstrate their competence to the Director-General of Health before they can be designated. They must prove they have the technical expertise to audit, effective systems in place to audit the specified services, effective arrangements to avoid conflicts of interest that may arise, and competent systems and arrangements.

**Monitoring**

The Ministry of Health, as the regulator in certifying services under the Safety Act, has an obligation to monitor hospitals, rest-homes and homes for people with disabilities. The Ministry will collect summaries of audit reports of all relevant services that apply for certification. From 1 October 2004 the Ministry will hold comprehensive audit information on all hospitals, rest-homes and homes for people with disabilities. This information will be held in an electronic database that will facilitate ready analysis. For example, the data could highlight areas where services are struggling to ensure safety and quality. Alternatively, the data could highlight areas of good practice that can be shared with all service providers. The information analysed will underpin future policy decisions related to the regulation of service safety in hospitals, rest-homes and homes for people with disabilities.
iv) Screening standards

Standards
Since the inception of the National Cervical Screening Programme (NCSP) in 1990/91, there has been a focus on meeting the requirements for an effective organised population-based screening programme and on providing ongoing systematic monitoring and evaluation of its various parts. Performance expectations for cervical screening are set out in Operational Policy and Quality Standards Manual. A set of national performance indicators and targets for the programme has also been developed to assist with the monitoring of the NCSP to improve the quality of the programme.

National quality standards for the provision of breast-screening services are outlined in a National Operational Manual, service specifications and national performance indicators. The indicators relate to key parameters in the screening pathway. The pathway is from registration of eligible women, testing and assessment, to diagnosis and treatment. The parameters have been chosen because they can be used as indicators of the safety, acceptability, effectiveness and efficiency of BreastScreen Aotearoa (the national breast-screening programme).

Monitoring
The quantitative performance of the NCSP is monitored by an Independent Monitoring Group. The group collates and analyses data against national indicators and targets. The analysis is provided in quarterly reports that include quality improvement recommendations. The National Screening Unit of the Ministry of Health co-ordinates information flow to assure feedback to providers, and undertakes analysis and follow-up of the recommendations to ensure delivery of consistent quality in the NCSP.

Aspects of the performance of BreastScreen Aotearoa (BSA) are monitored by an independent monitoring group against an agreed list of measures of performance, and are included in twice-yearly and annual monitoring reports to the Ministry of Health. The National Screening Unit of the Ministry of Health co-ordinates information flow to assure feedback to providers and undertakes analysis and follow-up of the recommendations with providers to ensure delivery of consistent quality in the BSA. A generic audit tool template has been developed for ensuring routine compliance by lead providers against National Quality Standards. A component of this audit tool is a survey that assesses the acceptability of the screening service for women.

These monitoring mechanisms will continue to be used and developed further for cervical and breast screening.
v) Health Practitioners Competence Assurance Bill

The Bill\(^2\) puts in place a new framework to ensure that the delivery of services by health practitioners is safe. There will be consistent processes for the registration and ongoing competence of practitioners who are currently regulated, and a process for the inclusion of new health professions, if appropriate. Registration authorities will certify that practitioners are qualified and competent to practise within a certain scope specifying conditions and time. The key features of the bill regulating health practitioners are outlined below.

Registration authorities
The Minister of Health will appoint the members of each registration authority, with provision for elected members to be appointed under regulations. The authorities will have at least two lay members. The registration authority will be separate from the association that represents a particular profession. The Minister of Health may instigate an audit of an authority’s policies and procedures if there is concern about its process.

Scopes of practice
Each registration authority will develop scopes of practice describing the activities practitioners are qualified to perform, the conditions under which the activities may be performed, and a date for review.

Restricted activities
Some activities, where there is a risk of serious or permanent harm, will be restricted to those who are competent to perform the activity according to their scope of practice.

Ongoing competence
Registration authorities will be required to put processes in place to ensure that practitioners maintain their competence throughout their careers.

Protected quality assurance activities (QAAs)
QAAs facilitate practitioners learning from patient outcomes, improving their competence and reducing adverse outcomes. By declaring a QAA the Minister of Health provides both confidentiality to information that becomes known as a result of the activity and immunity from civil liability to people who engage in the activity in good faith.

Complaints
All complaints about the services of a health practitioner go, in the first instance, to the Health and Disability Commissioner. The Commissioner will have discretion to refer the complaint to the appropriate registration authority if the Commissioner considers that the authority is the appropriate body to deal with it.

Each authority will set up a complaints investigation committee to investigate complaints referred to it for action. A range of options will be available to the authority for dealing with the complaint (eg, review competence, counselling, conciliation, or taking no further action).

\(^2\) The contents of the final Act are subject to the Parliamentary process. The material in this section relates to the content of the bill at the time of writing.
The Health Practitioners Disciplinary Tribunal
A single disciplinary tribunal will be established to hear complaints against all health practitioners that warrant significant disciplinary action.

Quality assurance expectations of District Health Boards
There are a number of documents relating to the Minister of Health’s relationship with DHBs. These documents establish quality, and safety-related expectations of DHBs. The key documents are:

- *Service Coverage* – this defines the range of services that DHBs are expected to fund access to for their populations. Specification of service coverage can include quality and safety expectations.
- *Operational Policy Framework* – this sets out the quasi-regulatory rules that all DHBs must comply with when providing and/or funding health and disability support services.

The requirements in these accountability documents are the mechanism for identifying nationally consistent standards and quality assurance programmes for publicly funded health and disability services, where these standards and assurance programmes are additional to those required by regulation or legislation.

DHBs’ progress in meeting the quality assurance expectations are monitored against the performance indicators and reporting arrangements between the Minister and Ministry of Health for reporting and assessing DHB performance. Consistent with a quality improvement approach, the quality assurance-related expectations of DHBs in the above documents are reviewed and refined from time to time.

Advisory committees
The New Zealand Public Health and Disability Act 2000 enables the Minister of Health to appoint members to:

- the National Health and Epidemiology and Quality Assurance Advisory Committee (Epiqual)
- the Mortality Review Committees (Ministerial committees can be established to review and report on specified classes of deaths, or deaths of specified persons. A Child and Youth Mortality Review Committee has been established).

These committees have roles that support quality improvement through the analysis and identification of various mortality and morbidity issues, with a view to informing improved sector performance.
Appendix 3: Major Health and Disability-related Acts and Regulations

Acts

Alcohol Advisory Council Act 1976
Alcoholism and Drug Addiction Act 1966
Burial and Cremation Act 1964
Cancer Registry Act 1993
Chiropractors Act 1982*
Dental Act 1988
Dieticians Act 1950*
Disabled Persons Community Welfare Act 1975
Health Act 1956
Health and Disability Commissioner Act 1994
Health and Disability Services (Safety) Act 2001
Health Benefits (Reciprocity with Australia) Act 1999
Health Benefits (Reciprocity with the United Kingdom) Act 1982
Health Sector (Transfers) Act 1993
Health Research Council Act 1990
Hospitals Act 1957
Human Tissue Act 1964
Medical Auxiliaries Act 1966*
Medical Practitioners Act 1995*
Medicines Act 1981
Mental Health Commission Act 1998
Mental Health (Compulsory Assessment and Treatment) Act 1992
Misuse of Drugs Act 1975
New Zealand Public Health and Disability Act 2000
New Zealand Register of Osteopaths Incorporated Act 1978
Nurses Act 1977*
Occupational Therapy Act 1949*
Optometrists and Dispensing Opticians Act 1976*
Pharmacy Act 1970*
Physiotherapy Act 1949*
Plumbers, Gasfitters and Drainlayers Act 1976
Psychologists Act 1981*
Radiation Protection Act 1965
Smoke-free Environments Act 1990
Tuberculosis Act 1948
Regulations and Orders in Council made pursuant to the above Acts

Alcohol Advisory Council Regulations 1978
Alcoholism and Drug Addiction Act Commencement Order 1968
Alcoholism and Drug Addiction (Forms) Regulations 1968
Alcoholism and Drug Addiction (Medical Fees) Regulations 1999
Anthrax Prevention Regulations 1987
Asbestos Regulations 1983
Burial and Cremation (Removal of Monuments and Tablets) Regulations 1967
Camping-Grounds Regulations 1985
Cancer Registry Regulations 1994
Chiropractors Amendment Act Commencement Order 1996
Cremation Regulations 1973
Dental Amendment Act Commencement Order 1996
Dental Regulations 1988
Dieticians Amendment Act Commencement Order 1996
Dieticians Regulations 1987
Electroplating Regulations 1950 (Amendments 4 and 5 are administered by the Department of Labour)
Environmental Health Officers Qualifications Regulations 1993
Exhumation Licence Fee Order 1991
Fire Extinguishers Regulations 1958
Fireguards Regulations 1958
Fumigation Regulations 1967
Health and Disability Commissioner Act Commencement Order 1996
Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996
Health and Disability Services (Safety) Exemption Order 2002
Health and Disability Services (Safety) Fees Regulations 2002
Health and Disability Services (Safety) Hospital Care, Residential Disability Care and Rest Home Care Standards Notice 2002
Health (Burial) Regulations 1946
Health (Bursaries) Regulations 1965
Health (Cervical Screening (Kaitiaki) Regulations 1995, reference to ‘Health Constituencies of District Health Boards’) Order 2001’
Health (Diseases Communicated by Animals) Regulations 1965
Health Benefits (Reciprocity with Australia) Act Commencement Order 1999
Health Benefits (Reciprocity with United Kingdom) Act Commencement Order 1984
Health (Constituencies of District Health Boards) Order 2001
Health Entitlement Cards Regulations 1993
Health (Hairdressers) Regulations 1980
Health (Immunisation) Regulations 1995
Health (Infectious and Notifiable Diseases) Regulations 1966
Health (Infirm and Neglected Persons) Regulations 1958
Health (Needles and Syringes) Regulations 1998
Health (Quarantine) Regulations 1983
Health Reforms (Transfer of Assets and Liabilities of Healthlink South Limited) Order 2000
Health Reforms (Transfer of Assets and Liabilities of Health Benefits Limited) Order 2000

IQ: A Systems Approach for the New Zealand Health and Disability Sector
Health (Registration of Premises) Regulations 1966
Health (Retention of Health Information) Regulations 1996
Health Sector Transfers (Enable New Zealand Limited) Order 2002
Health Sector Transfers (Housing New Zealand Corporation) Order 2002
Health Sector Transfers (Provider Arrangements) Order 2001
Health Sector Transfers (Provider Arrangements) Order 2001 (No. 2)
Health Sector Transfers (Provider Arrangements) Order 2002
Health Sector Transfers (Wellington City Council) Order 2002
Hospitals (Eligibility for Exemption) Notice 1996, 1996 (No. 2)
Hospitals Regulations 1993
Housing Improvement Regulations 1947
Infectious and Notifiable Diseases Order 1996
Infectious and Notifiable Disease (SARS) Order 2003
Infectious Diseases Order 1983
Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002
Intellectually Handicapped Persons Homes Regulations 1955
Kakapo Stream Pollution Control Order 1976
Lead Process Regulations 1950
Medical Auxiliaries Amendment Act Commencement Order 1996
Medical and Dental Auxiliaries Act Commencement Orders 1967, 1968, 1982 and 1996
Medical Laboratory Technologists Regulations 1989
Medical Practitioners Act Commencement Order 1996
Medical Practitioners Amendment Act Commencement Order 1996
Medical Practitioners (Quality Assurance Activities: Canterbury) Notice 1998
Medical Practitioners (Quality Assurance Activities: Eastbay) Notice 1998
Medical Practitioners (Quality Assurance Activities: Hutt Valley) Notice 1998
Medical Practitioners (Quality Assurance Activity: Albany Maternity & Gynaecology Limited) Notice 1999
Medical Practitioners (Quality Assurance Activity: Anaesthetists: Faculty of Intensive Care Programme) Notice 2001
Medical Practitioners (Quality Assurance Activity: Auckland Breast Cancer Study Group) Notice 2001
Medical Practitioners (Quality Assurance Activity: Auckland Hospital) Notice 1998
Medical Practitioners (Quality Assurance Activity: Boulcott Clinic) Notice 2002
Medical Practitioners (Quality Assurance Activity: Bowen Hospital Limited) Notice 2002
Medical Practitioners (Quality Assurance Activity: Capital Coast) Notice 1998
Medical Practitioners (Quality Assurance Activity: Dunstan Hospital) Notice 2002
Medical Practitioners (Quality Assurance Activity: First Health Limited) Notice 2002
Medical Practitioners (Quality Assurance Activity: General Practitioners: ProCare) Notice 1998
Medical Practitioners (Quality Assurance Activity: Hawke’s Bay) Notice 1999
Medical Practitioners (Quality Assurance Activity: Healthlink South) Notice 1999
Medical Practitioners (Quality Assurance Activity: Kensington Hospital) Notice 2002
Medical Practitioners (Quality Assurance Activity: Lakeland Health) Notice 1999
Medical Practitioners (Quality Assurance Activity: MercyAscot Hospitals) Notice 2003
Medical Practitioners (Quality Assurance Activity: MidCentral) Notice 1998
Medical Practitioners (Quality Assurance Activity: Nelson Marlborough) Notice 1998 (No. 2)
Medical Practitioners (Quality Assurance Activity: Northland) Notice 1999
Medical Practitioners (Quality Assurance Activity: Obstetricians and Gynaecologists) Notice 1998
Medical Practitioners (Quality Assurance Activity: Occupational Medicine) Notice 2000
Medical Practitioners (Quality Assurance Activity: Orthopaedic Services Limited) Notice 2002
Medical Practitioners (Quality Assurance Activity: Otago) Notice 1998
Medical Practitioners (Quality Assurance Activity: Pegasus Medical Group) Notice 2000
Medical Practitioners (Quality Assurance Activity: PrimeHealth Limited) Notice 2002
Medical Practitioners (Quality Assurance Activity: Psychiatrists) Notice 1998
Medical Practitioners (Quality Assurance Activity: Royston Hospital) Notice 2002
Medical Practitioners (Quality Assurance Activity: South Auckland) Notice 1998
Medical Practitioners (Quality Assurance Activity: South Canterbury District Health Board) Notice 2001
Medical Practitioners (Quality Assurance Activity: Southern Cross Hospital Trust) Notice 2001
Medical Practitioners (Quality Assurance Activity: Southern Health) Notice 1999
Medical Practitioners (Quality Assurance Activity: Tairawhiti) Notice 1998
Medical Practitioners (Quality Assurance Activity: Taranaki) Notice 1998
Medical Practitioners (Quality Assurance Activity: Waikato) Notice 1999
Medical Practitioners (Quality Assurance Activity: Waitakere) Notice 1999
Medical Practitioners (Quality Assurance Activity: Wakefield Hospital) Notice 2002
Medical Practitioners (Quality Assurance Activity: Wanganui) Notice 1999
Medical Practitioners (Quality Assurance Activity: Western Bay) Notice 1998
Medical Practitioners (Quality Assurance Activity: General Practitioner’s Advanced Vocational Education Programme) Notice 2003 (SR 2003/98)
Medical Practitioners (Vocational Registration) Orders 1996 and 1999
Medical Practitioners (Vocational Registration) Amendment Order 2003
Medical Radiation Technologists Regulations 1995*
Medicines Act Commencement Order 1984
Medicines Amendment Act Commencement Order 1994
Medicines (Approved Laboratories and Analysts in Charge) Notice 2000
Medicines (Designated Prescriber: Nurses Practising in Aged Care & Child Family Health) Regulations 2001
Medicines Regulations 1984
Medicines Regulations Amendment (No. 2) 2002
Medicines (Standing Order) Regulations 2002
Mental Health (Forms) Regulations 1992
Mental Health (Medical Fees) Regulations 1992
Mental Hospitals Road Traffic Bylaws 1960
Microwave Ovens Regulations 1982
Misuse of Drugs Act Commencement Order 1977
Misuse of Drugs Amendment Act Commencement Order 1996
Misuse of Drugs Amendment Act 1998 Commencement Order 1999
Misuse of Drugs (Approved Laboratories and Analysts in Charge) Notice 2000
Misuse of Drugs (Changes to Controlled Drugs) Order 2003
Misuse of Drugs (Classification of Fantasy) Order 2001
Misuse of Drugs (Classification of Fantasy) Order Commencement Order 2002
Misuse of Drugs (Detention) Regulations 1985
Misuse of Drugs (Interception Warrant) Regulations 1997
Misuse of Drugs Order 1978
Misuse of Drugs Order 1978 (No. 2)
Misuse of Drugs Order 1981
Misuse of Drugs Order 1982
Misuse of Drugs Order 1984
Misuse of Drugs Order 1984 (No. 2)
Misuse of Drugs Order 1998
Misuse of Drugs (Prohibition of Cannabis Utensils) Notice 1999
Misuse of Drugs Regulations 1977
New Zealand Public Health and Disability (Archives) Regulations 2001
Noxious Substances Notice 1958 and 1959
Noxious Substances Regulations 1954
Nurses Amendment Act Commencement Order 1996
Nurses Regulations 1986*
Obstetric Regulations 1986
Occupational Therapy Amendment Act Commencement Order 1996
Occupational Therapy Regulations 1964
Offensive Trades Order 1959
Old People’s Homes Regulations 1987
Optometrist and Dispensing Opticians Amendment Act Commencement Order 1996 Optometrists and Dispensing Opticians Regulations 1977
Pharmacy Amendment Act Commencement Order 1996
Pharmacy Registration Regulations 1972*
Pharmacy Regulations 1975
Physiotherapy Regulations 1979*
Plastic Wrapping Regulations 1979
Plumbers, Gasfitters, and Drainlayers Regulations 1977
Podiatrists Regulations 1982*
Porirua Hospital Traffic Bylaws 1969
Psychologists Amendment Act Commencement Order 1973
Psychologists Act Commencement Order 1984
Psychologists Amendment Act Commencement Order 1996
Psychologists Regulations 1996
Psychologists (Fees) Regulations 1998
Physiotherapy Amendment Act Commencement Order 1996
Radiation Protection Act Commencement Order 1973
Radiation Protection (Appeals) Regulations 1974
Radiation Protection Regulations 1982
Restricted Drugs Amendment Act Commencement Order 1983
Sanitary Plumbing (Exemption) Notice 1978
Smoke-free Environments Regulations 1999
Spray Coating Regulations 1962
Toxic Substances Act Commencement Orders 1979 and 1983
Tuberculosis Regulations 1951
University of Otago School of Anatomy Orders 1969 and 1988
Venereal Diseases Regulations 1982
Water Supplies Protection Regulations

* These Acts are expected to be repealed, and these Regulations are expected to be revoked, by the Health Practitioners Competence Assurance Bill when it passed as an Act.

Note: With the exception of the Health Practitioners Competence Assurance Bill, which is in its final stages, other Bills that are in progress at the time of writing, such as the Human Assisted Reproduction Technology Bill, have been excluded. Similarly any Supplementary Order Papers amending Bills have also been excluded.
References


