

# **The New Zealand Health and Disability System: Organisations and Responsibilities**

Briefing to the  
Minister of Health

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# 1 Overview of the health and disability system

Every New Zealander will, at some point in their lives, rely on our health and disability system. New Zealand's health and disability system is large and complex, with services delivered through a broad network of organisations (see Figure 1). Each has its role in working with others across and beyond the system to achieve better health and independence for New Zealanders.

This briefing provides an overview of the health and disability system as at October 2014. It describes the major organisations and structures in the system, along with their roles, functions and responsibilities. The primary focus of this briefing is on those organisations that fall within the Vote Health purview. However, these organisations alone cannot meet all of New Zealanders' health and disability needs. Strong collaboration and cooperation across government agencies and local government are essential to achieving good health, social and economic outcomes.

## A complex system, working together

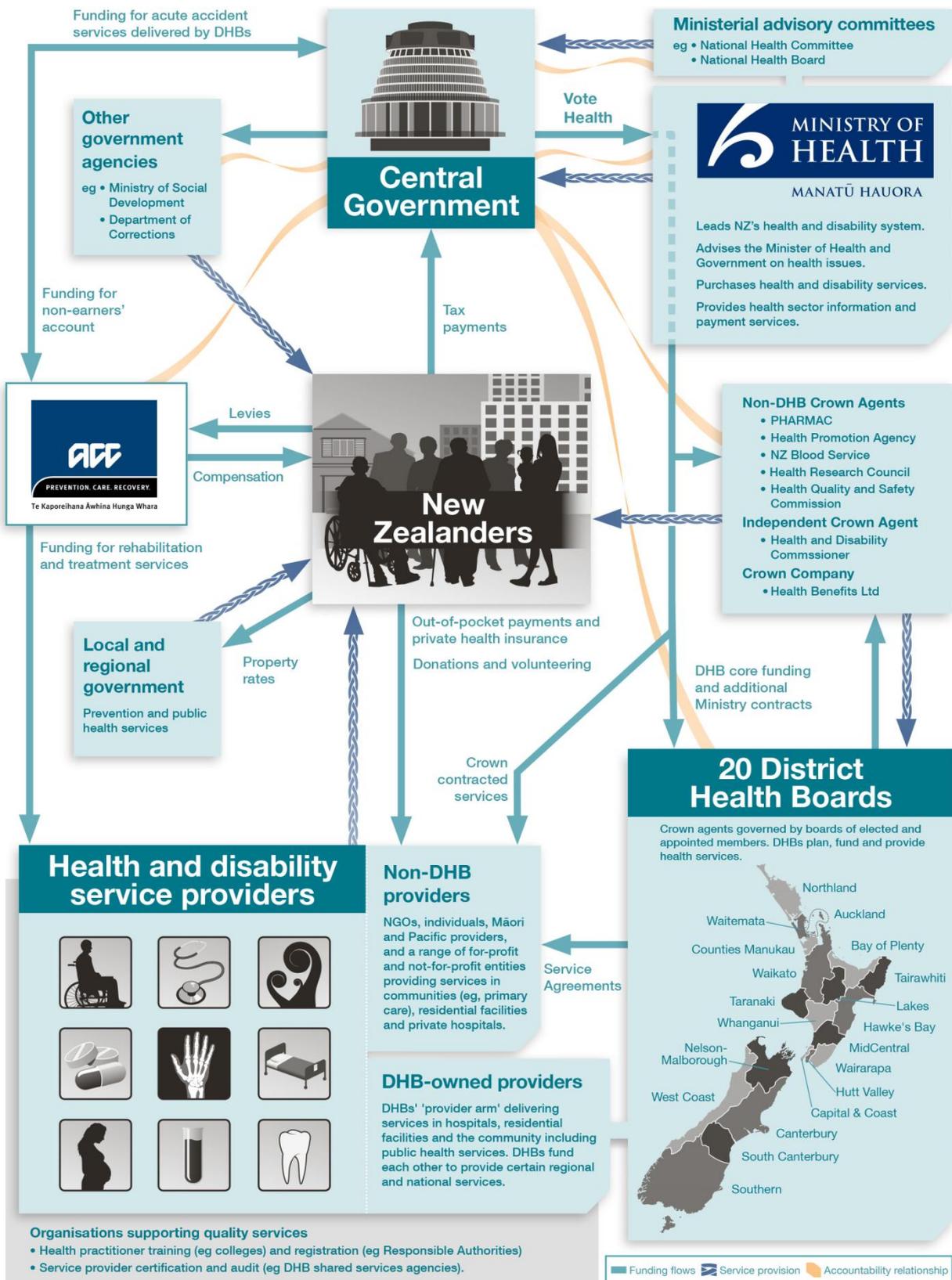
The Minister of Health, with Cabinet and the Government, develops policy for the health and disability sector and provides leadership. The Minister is principally supported and advised by the Ministry of Health, and further advised by the National Health Board, Health Workforce New Zealand, the National Health Committee and other ministerial advisory committees.

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

The Ministry has a range of roles in the system, in addition to being the principal advisor and support to the Minister. It funds an array of national services (including disability support and public health services), provides clinical and sector leadership, and has a number of monitoring, regulatory and protection functions.

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

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



# Statutory framework

The health and disability system's statutory framework is made up of over 25 pieces of legislation. The most significant are the New Zealand Public Health and Disability Act 2000 (the NZPHD Act), the Health Act 1956 and the Crown Entities Act 2004. Legislation the Ministry administers and other regulatory roles are listed in Appendix 1.

## New Zealand Public Health and Disability Act 2000

The NZPHD Act establishes the structure for public sector funding and the organisation of health and disability services. It mandates the New Zealand Health Strategy and New Zealand Disability Strategy, establishes DHBs and certain other Crown entities, and sets out the duties and roles of key participants, including the Minister and ministerial advisory committees.

## Health Act 1956

The Health Act sets out the roles and responsibilities of individuals to safeguard public health, including the Minister, the Director of Public Health and designated officers for public health. It contains provisions for environmental health, infectious diseases, health emergencies and the National Cervical Screening Programme.

## Crown Entities Act 2004

The Crown Entities Act 2004 provides the fundamental statutory framework for the establishment, governance and operation of Crown entities. It clarifies accountability relationships and reporting requirements between Crown entities, their boards and members, monitoring departments, responsible Ministers and Parliament.

# Funding the system

The health system's funding comes mainly from Vote Health, which is administered by the Ministry. For 2014/15 this totals \$15.557 billion, the Vote having grown from \$12.240 billion in 2008/09.

Other significant funding sources include other government agencies (most notably the Accident Compensation Corporation – ACC), local government and private sources such as insurance and out-of-pocket payments.

## Vote Health

The majority of public funds managed through Vote Health are allocated to DHBs: \$11.405 billion in 2014/15, or 73.3 percent of Vote Health. DHBs use this funding to plan, purchase and provide health services for the population of their district, so as to ensure effective and efficient services for all of New Zealand. DHBs oversee – but exercise varying control over – funding for all levels of care, including primary care, such as GPs, nurses and pharmacists. They also oversee funding for hospital services, aged care services and services provided by non-government health providers.

The Ministry spends 18.1 percent of Vote Health (\$2.845 billion) to directly purchase a range of services, such as disability support services, public health services, specific screening programmes, mental health services, elective services, Well Child and primary maternity

services, Māori health services, and postgraduate clinical education and training, as well as Māori and Pacific provider development.

In recent years, the Ministry has been working increasingly with other government social sector agencies (such as the Ministry of Social Development) to improve health and social sector outcomes. Amendments to the Public Finance Act 1989, made in July 2013, have provided greater flexibility for resources to be shared between departments and allocated to where they can best contribute to achieving results.

Capital funding comprises \$1.114 billion in 2014/15 (7.2 percent of Vote Health). This includes provision of debt or equity for DHBs (and other health Crown entities and/or Public Finance Act Schedule 4A companies) to cover new investments or other purposes agreed by the Crown.

Just over \$193 million of Vote Health (1.2 percent in 2014/15) goes to the Ministry's departmental functions in supporting the wider health and disability sector (this compares to \$227 million in 2008/09, or 1.9 percent of Vote Health at that time).

Graphs showing the breakdown of Vote Health are set out in Appendix 2.

## **Four-Year Plans**

The Treasury and State Services Commission require departments to develop a Four-Year Plan each year. The plan covers the coming four financial years and contains information on strategic intentions, how those intentions will be delivered, potential risks, financial pressures and commitments, workforce, Crown entities, and on how the government's plans for property and information technology will be supported.

The plan for Vote Health contains a mix of health sector information and information about the Ministry, and includes details of how the Ministry expects to manage financial pressures (eg, inflation and wage pressures), emerging issues (eg, ageing population and changes in disease patterns), and workforce challenges (eg, reliance on overseas trained medical professionals). Central agencies also expect the plan to cover the health sector's contribution to wider social sector outcomes.

The 2014 plan for Vote Health, covering 2015/16 to 2018/19, is due in draft to central agencies on 20 November 2014, with a final plan lodged by Budget day (May 2015). It is expected that the plan will have similar themes to that of 2013. Central agencies now require the Director-General of Health to sign and submit the plan, which differs from previous years where the Minister has done this.

The Ministry will consult with the Minister and seek the Minister's approval on the strategic intentions outlined in the 2014 plan, before submitting the draft plan. There will be further opportunities to engage on the 2014 plan in the months leading up to Budget 2015.

DHBs and other health Crown entities do not have to produce Four-Year Plans. However, information on them will be contained in the Ministry's plan.

## **Budget 2015**

The draft Four-Year Plans will provide central agencies with a 'state of play', indicating the current pressures and commitments facing the Government. These, along with the

Government's intentions, set the scene for Budget 2015 and should assist with decisions on funding allocations across the various portfolios.

Treasury advises it will run a Budget 2015 process for new initiatives in the New Year.

The Baseline Update exercise, which Treasury usually runs in February or March each year, provides an opportunity to adjust budgets and forecasts to reflect recent Cabinet decisions, operating matters (eg, rephrasing of capital projects) and other technical financial matters.

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## 2 Minister of Health

The Minister has overall responsibility for the health and disability system, and for setting the sector's strategic direction. The Minister's functions, duties, responsibilities and powers are provided for in the NZPHD Act, the Crown Entities Act 2004 and in other legislation. Some responsibilities may be delegated to one or more Associate Ministers of Health.

There are various ways the Minister, or the Ministry on the Minister's behalf, can direct activity in the sector. Because it is a semi-devolved system, many day-to-day functions and detailed decisions happen at a local level. Due to the system's complex set of governance, ownership, business and accountability models, the levers available to the Minister are varied and exert differing levels of control.

### Setting the strategic direction

#### System strategies

The Minister is responsible for strategies that provide a framework for the health and disability system. Key system strategies are described below.

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New Zealand Health Strategy	The Minister must determine a strategy for health services: the New Zealand Health Strategy (under the NZPHD Act). The Minister must report each year on progress in implementing the Strategy. If the Strategy is reviewed, the NZPHD Act requires consultation with appropriate organisations and individuals.
New Zealand Disability Strategy	The Minister for Disability Issues must determine a strategy for disability services: the New Zealand Disability Strategy (under the NZPHD Act). This Minister must report each year on progress in implementing the Strategy. If the Strategy is reviewed, the NZPHD Act requires consultation with appropriate organisations and individuals.
He Korowai Oranga: Māori Health Strategy	He Korowai Oranga: Māori Health Strategy sets the overarching framework to guide the Government and the health and disability sector to achieve the best health outcomes for Māori. He Korowai Oranga literally translated means 'the cloak of wellness'. The Strategy was refreshed in June 2014, expanding the aim of He Korowai Oranga from whānau ora to pae ora – healthy futures.
Primary Health Care Strategy	The Primary Health Care Strategy was developed in 2001 to provide a clear direction for the future development of primary health care in New Zealand. Although now somewhat dated, it remains a useful document that outlines the specific contributions primary health care makes to improving health outcomes.
Other strategies in the health sector	There are a number of strategies that guide specific areas of work in the health sector (eg, Cancer Control Strategy, Suicide Prevention Strategy, etc).

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## Ministry of Health

The Minister is also responsible for the strategic direction of the Ministry. This is set using the following documents:

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Statement of Intent	The Minister approves the Ministry's Statement of Intent. In signing this document, the Minister confirms he or she is satisfied that the information on the Ministry's strategic directions is consistent with the priorities and performance expectations of the Government.
Four-Year Plan/Budget	The Minister is consulted on, and approves, the strategic intentions outlined in the Ministry's plan for Vote Health. The Director-General of Health is responsible for signing and submitting the plan by Budget day.
Output Plan	The Minister agrees with the Director-General the Ministry's Output Plan. The Output Plan shows the Vote Health funded outputs the Ministry expects to deliver during the financial year. It also records the basis for the delivery of services and sets the performance, financial management and reporting standards the Ministry is expected to meet. The Director-General provides the Minister with four monthly progress reports against this Plan.

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## Ensuring a high performing system

Beyond setting the system's strategic direction, the Minister has an array of performance levers available. Given the Minister's legislative and financial responsibilities, specific levers are largely focused around ensuring strong performance from DHBs and other health Crown entities.

These levers can be broadly grouped into three categories, set out in further detail at Table 1.

1. Setting entities' strategic direction and annual performance requirements (eg, through Letters of Expectation, Statements of Intent/Statements of Performance Expectations, setting funding parameters and giving directions).
2. Monitoring strategic direction and results (eg, through a monitoring agent, discussing results with entities, requesting information).
3. Board appointments, remuneration and removals (eg, appointing chairs and members, setting terms and conditions of appointment, ensuring quality induction and review processes).

Additional details on these levers are included within the chapters on Crown entities (Chapter 5) and DHBs (Chapter 6).

**Table 1: Sample of Ministerial levers**

1. Setting entities' strategic direction and annual performance requirements	2. Monitoring strategic direction and results	3. Board appointments, remuneration and removals
<p><b>Set expectations:</b> Engage regularly on performance expectations (eg, talking to chairs, meeting boards, issuing annual Letters of Expectations).</p> <p><b>Require new Statement of Intent (SOI):</b> May require a new SOI at any time. An SOI may last up to three years and must cover four years.</p> <p><b>Extend or waive SOI:</b> In certain circumstances, may grant an extension or waive the requirement to provide an SOI.</p> <p><b>Amend SOI:</b> Comment on a draft SOI and may require amendments to some parts of the final SOI.</p> <p><b>Amend Statement of Performance Expectations (SPE):</b> Comment on a draft annual SPE and may require amendments to a final SPE, excluding forecast financials.</p> <p><b>Adjust funding:</b> May adjust Crown funding (eg, appropriations, fees, levies), subject to Cabinet consideration.</p> <p><b>Agree reporting:</b> Agree to in-year reporting requirements to ensure useful performance information is received.</p> <p><b>Give policy direction:</b> Give Crown entities a direction on government policy. Crown agents must 'give effect to' directions. Policy directions can only be given to an independent Crown entity if specifically provided for in an Act.</p> <p><b>Recommend whole of government direction be given:</b> Minister of State Services/Minister of Finance may jointly direct Crown entities to support whole of government approaches.</p> <p><b>Give DHB-specific direction:</b> Give DHBs a direction under NZPHD Act provisions (eg, in respect of eligibility, services, etc).</p>	<p><b>Choose a monitor:</b> Decide whether to have a monitor, and, if so, who that monitor is (the Ministry currently monitors entities for the Minister).</p> <p><b>Engage with entity chair/board and monitor:</b> Engage regularly with the chair/board and receive analysis from the monitor.</p> <p><b>Request information:</b> Request information on performance and operations at any time.</p> <p><b>Review performance:</b> Review performance and operations at any time.</p> <p><b>State Services Commissioner actions:</b> Ask the State Services Commissioner to act on issues (as per the State Sector Act 1988).</p> <p><b>No surprises:</b> Have a 'no surprises' policy in place.</p>	<p><b>Decide recruitment process:</b> Decide who will undertake board member recruitment, the scope of the process, and the skills required for the board (the Ministry currently assists the Minister with this process).</p> <p><b>Consult colleagues:</b> Consult ministerial colleagues via the Cabinet Appointments and Honours Committee (APH).</p> <p><b>Appoint:</b> Following referral to APH, make board appointments for Crown agents; recommend appointments for independent Crown entities to the Governor-General. For DHBs, Crown monitors can be appointed to assist performance.</p> <p><b>Set remuneration:</b> Set the remuneration for board members of Crown agents; Remuneration Authority sets the fee for independent Crown entities.</p> <p><b>Send appointment letters:</b> Send a clear appointment letter stating what is expected from each appointee.</p> <p><b>Expect induction:</b> Expect an induction for new appointees to occur; consider attending/participating or directing the monitor to provide the induction.</p> <p><b>Expect self-review:</b> Expect boards to undertake an annual self-review, raising any key issues as a result with the Minister.</p> <p><b>Reappoint:</b> Reappoint or not reappoint serving board members.</p> <p><b>Remove members:</b> Remove board members for Crown agents; recommend removals for independent Crown entities to the Governor-General. For DHBs, boards can be removed and replaced with commissioners.</p> <p><b>Court order:</b> Seek a court order requiring or restraining a board/member in relation to the Crown Entities Act 2004 or entity's enabling Act.</p>

Adapted from: State Services Commission. 2014. *Statutory Crown Entities: A Guide for Ministers*. URL: <http://www.ssc.govt.nz/crown-entities-guide-ministers> (accessed 2 October 2014).

# Other key roles under legislation

## Health emergencies

The Minister has the power to declare health emergencies under the Health Act 1956. This has the effect of unlocking various emergency powers for statutory officers across the sector, such as medical officers of health. The Prime Minister, in consultation with the Minister, has the power to issue an epidemic notice under the Epidemic Preparedness Act 2006, which allows a broader range of possible responses.

## Health inquiries

The Minister has the power under the NZPHD Act to order inquiries into the funding or provision of health and/or disability support services, the management of DHBs or other health Crown entities established under the NZPHD Act, or act a complaint or matter that has arisen. This can be done through either a commission of inquiry or an inquiry board that conducts the inquiry (or investigation, in the case of a commission) and reports back to the Minister.

## Responsibilities under mental health legislation

New Zealand's mental health legislation allows for the compulsory assessment and treatment of people with a mental disorder who pose a serious danger to themselves or others, or have a seriously diminished capacity to take care of themselves.

The Minister is responsible for, and obliged to make, around 60 decisions a year about extended leave from hospital, and eventual change of legal status, for special and restricted patients (ie, patients who enter secure mental health services via the courts after committing some serious criminal offence, or by transfer from prison when in need of compulsory treatment).

The Minister also appoints district inspectors and members of the Mental Health Review Tribunal (see Appendix 3).

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# 3 Ministry of Health

The Ministry is the Government's principal agent in the New Zealand health and disability system and has overall responsibility for the stewardship of that system. The Ministry acts as the Minister's principal advisor on health policy, thereby playing an important role in supporting effective decision-making. At the same time, the Ministry has a role within the health sector as a funder, monitor, purchaser and regulator of health and disability services.

In this way, the Ministry provides leadership across the system and is the Government's primary agent for implementing the Government's health priorities and policies within the system. The Ministry also has a wider role in coordinating action with other government agencies to deliver on the Government's agenda across the spectrum of social sector services.

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

## Purpose and role

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

- its leadership of New Zealand's health and disability system
- advising the Minister and the Government on health issues
- directly purchasing a range of national health and disability support services
- providing health sector information and payment services for the benefit of all New Zealanders.

The Ministry works in partnership with other public sector agencies and by engaging with people and their communities in carrying out these roles.

## Leadership

The Ministry leads the health and disability system, and has overall responsibility for the management and development of that system. It steers improvements that help New Zealanders live longer, healthier and more independent lives.

The Ministry ensures that the health system is delivering on the Government's priorities and that health sector organisations are well governed and soundly managed from a financial perspective. To do this, the Ministry:

- funds, monitors and drives the performance improvements of DHBs and other health Crown entities
- supports the planning and accountability functions of DHBs and other health Crown entities
- regulates the sector and ensures legislative requirements are being met.

See Chapter 8 for information about the Ministry's leadership internationally.

## **Advising the Government**

Health and disability policy choices are complex and challenging, and the Ministry has a responsibility to provide clear and practical advice to the Minister and Associate Ministers, supported by strong, evidence-informed analysis.

The Ministry provides expert clinical and technical advice to Ministers, organisations and individuals within the health and disability sector. Some Ministry functions (such as those that rest with the Director of Public Health) include clinical decision-making or statutory responsibilities.

## **Buying health and disability services**

The Ministry is a funder, purchaser and regulator of national health and disability services on behalf of the Crown. These services include:

- public health interventions (eg, immunisation)
- disability support services
- elective services
- screening services (eg, cervical screening)
- mental health services
- maternity services
- ambulance services.

## **Information and payments**

The Ministry provides key infrastructure support to the health and disability system, especially through:

- the provision of national information systems
- a payments service to the health and disability sector (totalling \$7.5 billion of Ministry and sector payments made per annum; around 1.8 million claims).

## **Priority areas**

The improved wellbeing and health of New Zealanders will be achieved by the delivery of services that are accessible, safe, individual and family-centred, clinically effective and cost-effective. The Ministry has a multi-faceted strategy, as is appropriate for a complex sector. As set out in the Ministry's Statement of Intent 2014–2018 (published June 2014), the Ministry will:

1. contribute to the Government's strategic priorities by:
  - delivering Better Public Services within tight financial constraints
  - responsibly managing the Government's finances
  - supporting Christchurch
  - building a more competitive and productive economy.

2. deliver on the Government's other priority actions through:
  - Supporting Vulnerable Children
  - Whānau Ora
  - the Prime Minister's Youth Mental Health project
  - health targets
  - Tackling Methamphetamine: An Action Plan
  - social sector trials
  - the Australia New Zealand Therapeutic Products Agency
  - Smokefree 2025.
3. implement the Minister's objectives for the sector, which are to:
  - maintain wellness for longer by improving prevention
  - improve the quality and safety of health services
  - make services more accessible, including more care closer to home
  - implement Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017
  - support the health of older people
  - make the best use of information technology and ensure the security of patients' records
  - strengthen the health and disability workforce
  - support regional and national collaboration.

## Building for Our Future

Building for Our Future is an organisational improvement programme, established in response to the Ministry's first Performance Improvement Framework review in 2012 (see Figure 2). It is designed to prepare the Ministry for the challenges facing the health and disability sector in the coming years.

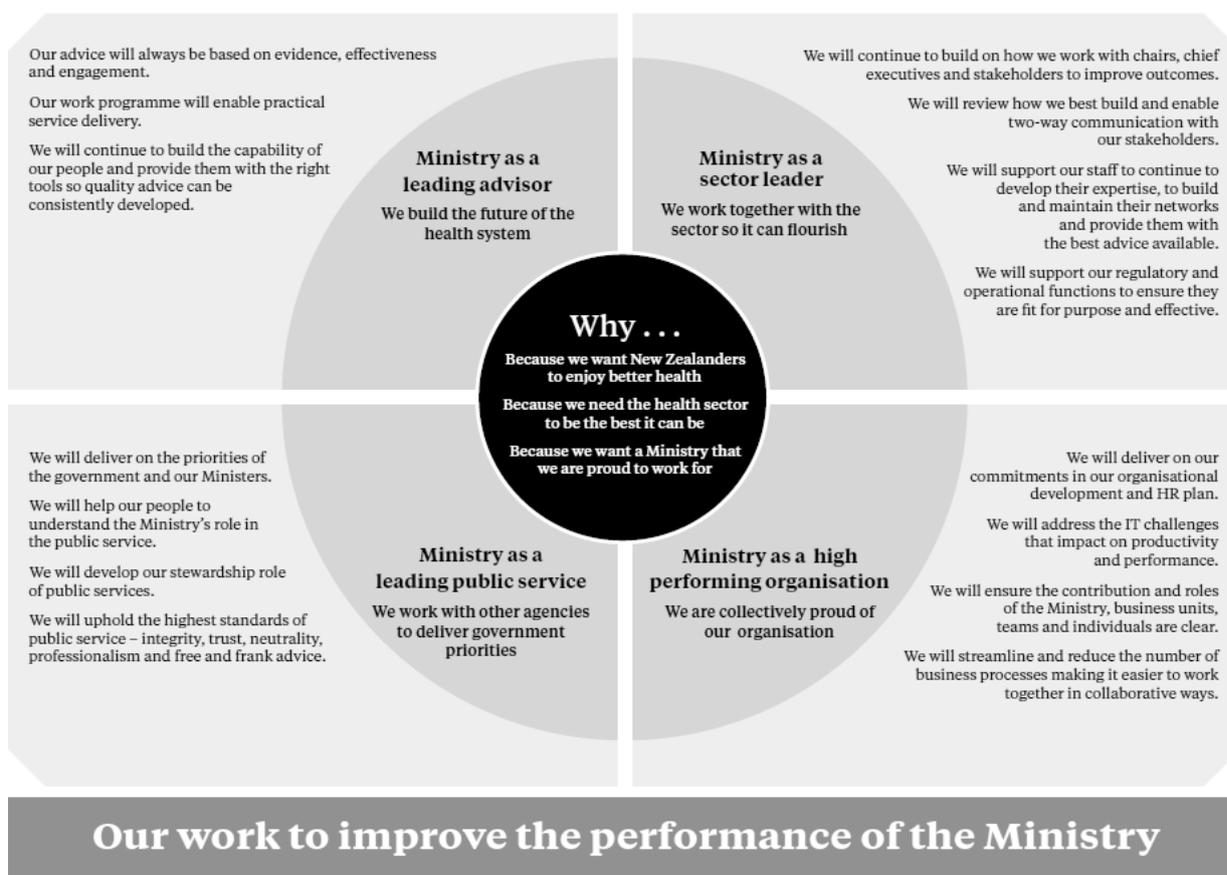
Building for Our Future has been developed with staff and stakeholder engagement, and by reference to performance benchmarks and external reviews. The programme aims to develop the Ministry as a:

- leading advisor
- sector leader
- leading public service
- high-performing organisation.

Work most relevant to organisational health and capability in the Ministry includes:

- recruitment and retention
- organisational development
- individual performance
- staff engagement
- equal employment opportunities.

**Figure 2: Building for Our Future**



## Statutory positions

### Director-General of Health

The Director-General of Health is the chief executive of the Ministry and, like most Public Service chief executives, is appointed on a fixed-term contract by the State Services Commissioner under the State Sector Act 1988. In addition to responsibilities in the State Sector Act, the Director-General has a number of other statutory powers and responsibilities under various pieces of health legislation. These include:

- powers relating to the appointment and direction of statutory public health officers, oversight of the public health functions of local government, and authorising the use of special powers for infectious disease control under the Health Act 1956
- certifying providers under the Health and Disability Services (Safety) Act 2001
- issuing guidelines under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and other Acts.

The Director-General is the Psychoactive Substances Regulatory Authority under the Psychoactive Substances Act 2013. This role is currently delegated to the Group Manager, Medsafe, and the Manager, Psychoactive Substances, Medsafe.

Chai Chuah is the Acting Director-General of Health. The State Services Commissioner will brief you on the process to appoint the Director-General of Health.

## **Director of Mental Health**

The positions of Director and Deputy Director of Mental Health are both provided for in the Mental Health (Compulsory Assessment and Treatment) Act 1992. The Director of Mental Health is responsible for the general administration of the Act under the direction of the Minister and Director-General. The Director is also the Chief Advisor, Mental Health, and is responsible for advising the Minister on mental health issues.

The Director's functions and powers under the Act allow the Ministry to provide guidance to mental health services, supporting the strategic direction provided in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* and a recovery-based approach to mental health.

The Deputy Director of Mental Health is required to perform such duties as the Director may require. The Deputy Director is also the Ministry's Senior Advisor, Mental Health.

Dr John Crawshaw is the Director of Mental Health. Dr Arran Culver is the Deputy Director of Mental Health.

## **Director of Public Health**

The Director of Public Health position is provided for in the Health Act 1956. The Director of Public Health has the authority to independently advise the Director-General and Minister on any matter relating to public health. The Director also provides national public health professional leadership, and professional support and oversight for district medical officers of health. Two Deputy Directors of Public Health assist the Director of Public Health in carrying out both statutory and non-statutory responsibilities.

Dr Darren Hunt is the Director of Public Health.

Dr Fran McGrath is Deputy Director of Public Health, and Harriette Carr is Acting Deputy Director of Public Health.

## **Chief Financial Officer**

The Public Finance Act 1989 requires all departments to have a Chief Financial Officer responsible for the quality and completeness of the department's Statement of Intent and annual accounts. The Chief Financial Officer ensures that internal controls are effective and efficient.

Mike McCarthy is the Chief Financial Officer.

# Public service key positions

Section 50 of the State Sector Act gives the State Services Commissioner the ability to designate roles within a department or departmental agency, after consulting with the relevant chief executive, as 'key positions' in the public service. When appointing to a key position within their department, chief executives are required to obtain the agreement of the Commissioner before making the appointment.

There are currently five key positions in the Ministry of Health:

- Deputy Director-General, Policy (Don Gray)
- National Director, National Health Board (Chai Chuah; Michael Hundleby is acting in this role while Chai Chuah is Acting Director-General of Health)
- Director, Emergency Management (Charles Blanch)
- Chief Information Officer (Graeme Osborne)
- Chief Advisor, Sector Employment Relations (Yvonne Bruorton).

## Executive Leadership Team

The Ministry's Executive Leadership Team (ELT) focuses on strategic management, corporate governance and organisational performance. ELT supports the Director-General of Health by:

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

ELT membership is decided by the Director-General and currently comprises:

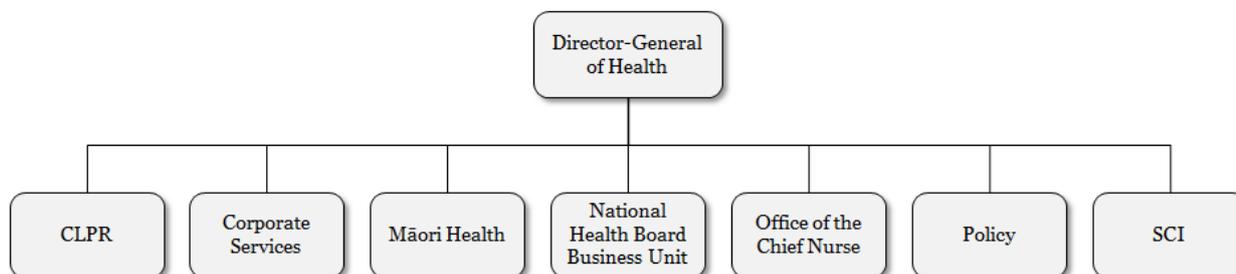
- Chai Chuah: Acting Director-General of Health and Chief Executive
- Don Gray: Deputy Director-General, Policy
- Michael Hundleby: Acting National Director, National Health Board Business Unit (this role is held by Chai Chuah when not Acting Director-General of Health)
- Dr Don Mackie: Chief Medical Officer, Clinical Leadership, Protection and Regulation
- Cathy O'Malley: Deputy Director-General, Sector Capability and Implementation
- Dr Jane O'Malley: Chief Nurse
- Barbara Phillips: Deputy Director-General, Corporate Services
- Teresa Wall: Deputy Director-General, Māori Health.

Other key Ministry staff attend ELT meetings, including Mike McCarthy (Chief Financial Officer) and Graeme Osborne (Chief Information Officer).

# Business units

The Ministry has seven business units: Clinical Leadership, Protection and Regulation (CLPR); Corporate Services; Māori Health; National Health Board Business Unit; Office of the Chief Nurse; Policy; and Sector Capability and Implementation (SCI).

**Figure 3: Structure of the Ministry of Health**



Under the Government's capping policy, staff numbers in core government administration must not exceed 36,475 positions. The Ministry currently makes up 1173 of these positions, spread across the seven business units, and intends to reduce its future numbers to ensure the overall cap is not breached. The Ministry is forecasting to reduce its positions to 1150 on 31 December 2014 and to 1100 on 31 December 2015.

## Clinical Leadership, Protection and Regulation

Dr Don Mackie, Chief Medical Officer, leads the Clinical Leadership, Protection and Regulation (CLPR) business unit.

CLPR provides leadership and advice on overarching clinical matters within the Ministry, and leadership on key issues in the health and disability sector. The business unit is led by the Chief Medical Officer. The core roles and functions of CLPR are:

- clinical leadership – ensuring that clinical perspectives inform the Ministry's strategic direction and prioritisation of the work programme. There are four chief advisor roles in CLPR that provide advice and leadership regarding integrative care, health and disability services, child and youth health, and population health.
- health protection – CLPR includes the statutory roles of the Director of Public Health and the Director of Mental Health and related regulatory and operational functions. This includes improving, promoting and protecting the health of New Zealanders from potential harm caused by communicable diseases and environmental hazards.
- regulation – through CLPR's regulatory units, HealthCERT, Medicines Control and Medsafe, it is responsible for:
  - ensuring that hospitals, rest homes, residential disability facilities and fertility services provide safe and reasonable levels of service for consumers
  - overseeing the distribution chain of medicines and controlled drugs within New Zealand
  - assessing and approving medicines, approving clinical trials, classifying medicines, auditing and licensing medicine manufacturing sites, surveillance and compliance monitoring, overseeing product recalls, adverse reactions monitoring for medicines, maintaining a database of medical devices on the New Zealand market and providing advice and warnings of the safety of medicines available on the New Zealand market
  - licensing and overseeing radioactive sources in New Zealand

- approving psychoactive substances that pose no more than a low risk of harm, ensuring manufacturers comply with Good Manufacturing Practice and administering a licensing scheme covering manufacturers, importers, researchers, wholesalers, and retailers of these substances/products (once the current moratorium on processing applications ends).

## **Corporate Services**

Barbara Phillips, Deputy-Director General, Corporate Services, leads the Corporate Services business unit.

Corporate Services supports the Ministry, the Minister and the public to make a positive difference to health by providing a range of centralised advice and services. Examples of Corporate Services' work include:

- providing effective support to Ministers, including drafting ministerial correspondence and responses to parliamentary questions, coordinating briefings and Official Information Act requests, and assisting the Minister with the appointments process for boards and committees
- running the Ministry's central finance function, which includes managing the annual Budget process and the Four-Year Plan
- providing legal advice to the Ministry, and ensuring a comprehensive governance, risk and assurance framework is in place
- supporting the Ministry's strategic development and business planning processes (eg, preparing the Statement of Intent, Output Plan and Annual Report)
- delivering Human Resource services, from payroll through to organisational development (eg, the Building for Our Future programme)
- providing communications advice to the Ministry, and publishing health information for the sector and the wider public
- ensuring that the Ministry has a secure and comfortable environment that is conducive to productivity.

## **Māori Health (Te Kete Hauora)**

Teresa Wall, Deputy Director-General, Māori Health, leads Te Kete Hauora.

Te Kete Hauora sets the direction for Māori health, and provides support and guidance to the health sector to achieve equity in health and disability outcomes for Māori in New Zealand. This is achieved by:

- leading the coordination of accountability frameworks that monitor and drive sector performance
- producing Māori health monitoring reports
- building the evidence base through commissioning research
- providing oversight for the sector on issues that affect the quality of ethnicity data collection and health literacy
- providing both an equity analysis and a Māori population focus to the Ministry's development of policy advice
- providing advice across the Ministry to ensure high-quality services are accessible to Māori
- supporting the implementation of Whānau Ora across the health and social sectors

- leadership in the development and implementation of He Korowai Oranga: Māori Health Strategy through the development of tools, evidence and data
- ensuring DHBs meet their legislative requirements to enable Māori to participate in decision-making and service delivery
- providing advice on rongoā service development, including the provision of rongoā services (Māori traditional healing).

## **National Health Board Business Unit**

Michael Hundleby is the Acting National Director of the National Health Board Business Unit (the position of National Director is Acting Director-General Chai Chuah's substantive role).

The National Health Board Business Unit is made up of seven groups, each with its own director. Each group plays an important part in delivering improvements to the New Zealand health and disability sector. The National Health Board Business Unit is responsible for:

- supporting the National Health Board (a ministerial advisory committee; see page 22)
- national planning and preparedness activities for health emergencies (such as a pandemic) or emergencies that require the health sector to respond
- leading and coordinating the planning and development of the country's health and disability workforce
- providing strategic leadership on investment, in and use of, information systems across the health and disability sector
- planning, funding and purchasing national health and disability services
- managing stronger alignment of service, capital and capacity planning
- working with DHBs to improve their performance
- managing Monitoring and Intervention Framework processes, and providing support and interventions to DHBs if performance issues are identified
- providing quantitative advice relating to health service and sector performance, service planning, costing, pricing and resource allocation.

## **Office of the Chief Nurse**

Dr Jane O'Malley is the Chief Nurse.

The Office of the Chief Nurse provides clinical leadership, policy and strategic advice to the Minister, the Ministry, government agencies and the sector, to optimise the contribution of nursing to government objectives and to the health and wellbeing of New Zealanders. The Office provides expert input into health and disability services funding, monitoring and planning through collaborative clinical leadership.

## **Policy**

Don Gray, Deputy Director-General, Policy, leads the Policy business unit.

Policy is the lead Ministry business unit for developing and providing policy advice to Ministers and carrying out related policy functions. Policy provides advice that:

- positions the health and disability system to deliver on Government policy, respond to emerging priorities and meet future challenges

- develops solutions to improve the health, independence and wellbeing of specific populations
- improves how health services and support are delivered to develop new or creative solutions to long-term challenges
- provides economic analysis, advice and influence to increase value for money and fiscal sustainability.

Policy also covers the functions of:

- health and disability intelligence – monitoring the health of New Zealand’s population and the performance of the health system over time
- supporting the National Health Committee to advise on all (non-pharmaceutical) new diagnostic and treatment services and significant expansions of existing services
- providing analytical and administrative support to committees (eg, the Advisory Committee on Assisted Reproductive Technology and the National Ethics Advisory Committee).

## **Sector Capability and Implementation**

Cathy O’Malley, Deputy Director-General, Sector Capability and Implementation (SCI), leads the SCI business unit.

SCI works closely with the health sector to implement the Government’s strategic health priorities and other key priorities. SCI is responsible for:

- developing initiatives to improve access, quality and continuity of maternity, child and youth health services to support better outcomes for women, children and young people
- designing and implementing initiatives that will help to deliver on the Government’s health targets and other Government priorities, and ensuring these are delivered efficiently and effectively
- supporting and encouraging greater system and clinical integration
- improving health sector performance by contributing to cross-agency work
- developing strategies for more integrated patient care, and the sharing of best practice, innovations, new evidence and learning across the sector.

SCI’s work is structured into the following broad groupings: Community Health Service Improvement, Personal Health Service Improvement (including cardiovascular disease, diabetes and long-term conditions, cancer services, tobacco control and oral health), Māori Health Service Improvement, Pacific programme implementation, Mental Health Service Improvement, and System Integration.

## **Clinical leadership roles within the Ministry**

The Ministry employs health practitioners from a variety of backgrounds in a range of clinical leadership roles. These staff provide clinical expertise and sector leadership, and manage clinical areas of the Ministry’s work programme. The Ministry’s clinical leadership is jointly led by the Chief Medical Officer and the Chief Nurse, who co-chair the Clinical Leaders Steering Group.

## Chief Medical Officer

The Chief Medical Officer provides support and advice on clinical matters to the Director-General and other key stakeholders, clinical leadership and direction, and expert input into health services planning. The Chief Medical Officer leads the Clinical Leadership, Protection and Regulation business unit.

Dr Don Mackie is the Chief Medical Officer.

## Chief Nurse

The Chief Nurse provides expert advice on nursing to government, provides professional leadership to the nursing profession, and ensures an effective New Zealand contribution to nursing and health policy in international forums (eg, the World Health Organization) and a close association with Australian colleagues (through the Australian and New Zealand Council of Chief Nurses). The Chief Nurse leads the Office of the Chief Nurse business unit.

Dr Jane O'Malley is the Chief Nurse.

## Clinical leaders

Clinical leaders provide technical advice on a specific health topic or service. The Ministry's clinical leaders are based in the National Health Board Business Unit.

Marli Gregory	Clinical Leader – BreastScreen Aotearoa
Dr Hazel Lewis	Clinical Leader – National Screening Unit
Kim McAnulty	Clinical Leader – Radiology (electives)
Chris McEwan	Clinical Leader – Prioritisation (electives)
Dr Chris Wong	Clinical Leader – Public Health

## Chief advisors

Chief advisors are recognised leaders in their fields and have extensive experience across policy and strategy formation, implementation and management, as well as clinical or professional practice. In addition to the Chief Medical Officer and the Chief Nurse, there are chief advisors across several of the Ministry's business units.

## Clinical Leadership, Protection and Regulation

Dr John Crawshaw	Chief Advisor – Mental Health and Director of Mental Health
Gillian Grew	Chief Advisor – Services
Dr Chrissie Pickin	Chief Advisor – Population Health
Dr David St George	Chief Advisor – Integrative Care
Dr Pat Tuohy	Chief Advisor – Child & Youth Health

## Corporate Services

Phil Knipe	Chief Legal Advisor
Mike McCarthy	Chief Financial Officer

## **National Health Board Business Unit**

Amanda Smith	Chief Advisor – Disability, and Director – Intellectual Disability (Compulsory Care & Rehabilitation)
Yvonne Bruorton	Chief Advisor – Sector Employment Relations

## **Policy**

Bronwyn Croxson	Chief Economist
Yvonne Lucas	Chief Negotiator (International)

## **Sector Capability and Implementation**

Keriana Brooking	Chief Advisor – Service Improvement and Change
Hilda Fa’aselele	Chief Advisor – Pacific Health Improvement
Dr Robyn Haisman-Welsh	Chief Dental Officer
Dr Bryn Jones	Chief Advisor – Sector Capability and Implementation
Dr Peter Jones	Chief Advisor – Community Health Service Improvement
Wi Keelan	Chief Advisor – Māori Health Service Improvement
Andi Shirtcliffe	Chief Advisor – Pharmacy

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## 4 Ministerial advisory committees

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

Health legislation allows the Minister to establish committees, such as the National Health Board and Health Workforce New Zealand, under section 11 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act). Under section 16 of the NZPHD Act, the Minister must appoint a national advisory committee on health and disability support services ethics (the National Ethics Advisory Committee). Ad hoc committees can also be established.

### National Health Board and subcommittees

Cabinet decided to establish the National Health Board (NHB) under section 11 of the NZPHD Act, following the 2009 Ministerial Review Group report<sup>1</sup>, to provide advice to both the Director-General of Health and the Minister on the performance of the core Ministry functions delivered by the National Health Board Business Unit [CAB Min (09) 37/13-15 refers]. The Capital Investment Committee and the National Health IT Board were subsequently created as subcommittees of the NHB.

#### National Health Board

The NHB's role is to provide advice to the Minister and the Director-General of Health on the functions delivered by the National Health Board Business Unit. The NHB is accountable to the Minister for the quality and timeliness of its advice and reports, and operating within relevant legislative parameters (including the NZPHD Act, Public Finance Act 1989, State Sector Act 1988 and Official Information Act 1982). The Director-General of Health is accountable for the performance of the National Health Board Business Unit and gives due regard to the advice provided by the NHB.

The Minister appoints the chair and members of the NHB.

The Acting Chair of the NHB is Hayden Wano.

#### Capital Investment Committee

The Capital Investment Committee is a subcommittee of the NHB which provides advice to the Minister, the NHB and the Ministry. The Committee provides advice on matters relating to capital investment and infrastructure in the public health sector in line with the Government's service planning direction. This includes working with DHBs to review their business case

<sup>1</sup> Ministerial Review Group. 2009. *Meeting the Challenge: Enhancing sustainability and the patient and consumer experience within the current legislative framework for health and disability services in New Zealand – Report of the Ministerial Review Group*. URL: <http://www.beehive.govt.nz/release/ministerial-review-group-report-released> (accessed 2 October 2014).

proposals, prioritisation of capital investment and delivery of a National Asset Management Plan, and any other matters that the Minister (through the NHB) or the NHB may refer to it.

The NHB appoints the chair and members of the Committee after consultation with the Ministers of Health and Finance.

The Chair of the Capital Investment Committee is Evan Davies.

## **National Health IT Board**

The National Health IT Board, also a subcommittee of the NHB, provides advice to the Minister, the NHB and the Ministry. The Board provides advice on strategic leadership on the implementation and use of information and information technology (IT) systems across the sector, and on ensuring IT strategy is reflected in capital allocation and capacity planning.

The NHB appoints the chair and members of the Board after consultation with the Minister.

The Chair of the National Health IT Board is Dr Murray Milner.

## **Health Workforce New Zealand**

Health Workforce New Zealand (HWNZ) is an advisory board established under section 11 of the NZPHD Act at the same time as the NHB. It advises the Minister and the Director-General of Health on the performance of the Ministry's Health Workforce unit (housed within the National Health Board Business Unit), which aims to ensure that the New Zealand public has a health care workforce fit to meet its needs. Its work includes supporting and funding workforce development initiatives, financial support for postgraduate programmes and schemes to target hard-to-staff communities and specialties.

The Minister appoints the chair and members of HWNZ.

The Chair of HWNZ is Professor Des Gorman.

## **National Health Committee**

The National Health Committee (NHC; full title National Advisory Committee on Health and Disability) was established under sections 11 and 13 of the NZPHD Act, and was reconfigured in 2011 following the 2009 Ministerial Review Group report. The NHC provides the Minister with evidence-based independent advice on the introduction, significant expansion or reprioritisation of existing health care technologies. The World Health Organization (WHO) defines technology as anything from a pharmaceutical, medical device or medical equipment, through to interventions, health care systems and models of care.

NHC is primarily focused on models of care, and provides the Minister with advice on the kinds – and relative priorities – of health services that should be publicly funded. In doing so, it must ensure its advice takes into account clinical safety and effectiveness concerns, economic impacts, societal or ethical considerations and feasibility of adoption considerations. NHC's mandate requires it to provide recommendations that improve health outcomes for all New Zealanders, within the country's financial resources. NHC incorporates the Public Health Advisory Committee, which provides it with advice on public health issues.

NHC is supported by a specialist team employed by the Ministry of Health, with a general manager reporting to the Deputy Director-General Policy. NHC is currently working on models of care for ischaemic heart disease, chronic obstructive pulmonary disease, haematuria, and three issues referred by the sector. It also has an innovation fund (\$3 million) which is used to ensure the production of evidence for promising technologies and the targeted encouragement of innovation in the sector. NHC works closely with the Health Research Council and Callaghan Innovation to deliver these outcomes.

The Minister appoints the chair and members of the NHC.

The Chair of the NHC is Associate Professor Anne Kolbe.

## **Other ministerial advisory committees**

Around 30 other committees, groups and forums provide additional advice to the Minister. These include:

- Cancer Control New Zealand, which provides an independent, sustainable focus for cancer control
- the National Ethics Advisory Committee, which provides advice to the Minister on ethical issues and determines nationally consistent ethical standards across the health sector
- four regional Health and Disability Ethics Committees, which provide independent ethical review of health and disability research, and innovative practice to safeguard the rights, health and wellbeing of consumers and research participants
- the Ethics Committee on Assisted Reproductive Technology (ECART), which considers and determines applications for assisted reproductive procedures, extending the storage period of gametes and embryos, and human reproductive research, and reviews and monitors the progress of approvals
- the Advisory Committee on Assisted Reproductive Technology (ACART), which issues guidelines and advice to ECART and provides advice to the Minister on assisted reproductive procedures and human reproductive research.

Additional information on the above committees, and details of other advisory committees and health sector bodies, are provided in Appendix 3.

# 5 Crown entities

Crown entities are defined under the Crown Entities Act 2004 as entities that fall within five broad categories:

- statutory entities (ie, Crown agents, autonomous Crown entities and independent Crown entities)
- Crown entity companies
- Crown entity subsidiaries (ie, companies controlled by Crown entities)
- school boards of trustees
- tertiary education institutions.

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

There are 26 statutory entities and one Crown-owned company (listed under Schedule 4A to the Public Finance Act 1989) in the Health portfolio, as summarised at Table 2. DHBs also hold shares in a number of companies, which are classed as ‘Crown entity subsidiaries’ for the purposes of the Crown Entities Act (see page 36).

**Table 2: Entity/company classifications, office holders and chief executives**

Type	Entity	Chair	Deputy chair	Chief executive
<b>Crown agent</b> Crown agents must give effect to policy that relates to the entity’s functions and objectives if directed by Minister. The Minister appoints board members and has the power to remove a board member from office at his or her discretion.	DHBs (20)	<i>This information is provided on page 35.</i>		
	Health Promotion Agency	Dr Lee Mathias	Rea Wikaira	Clive Nelson
	Health Quality & Safety Commission	Prof Alan Merry	Shelley Frost	Dr Janice Wilson
	Health Research Council of New Zealand	Sir Robert Stewart	Prof Richard Beasley	Lex Davidson (Acting Chief Executive)
	New Zealand Blood Service	David Chamberlain	David Wright	Fiona Ritsma
	Pharmaceutical Management Agency (PHARMAC)	Stuart McLauchlan	[Vacant]	Steffan Crausaz
<b>Autonomous Crown entity</b> Autonomous Crown entities must have regard to policy that relates to the entity’s functions and objectives if directed by Minister. The Minister appoints board members and may remove a board member from office with a justifiable reason.	There are no autonomous Crown entities in the health portfolio. Previously, the Alcohol Advisory Council of New Zealand (ALAC) fell within this classification. ALAC and the Health Sponsorship Council were merged in 2012 to create the Health Promotion Agency (a Crown agent).			

Type	Entity	Chair	Deputy chair	Chief executive
<p><b>Independent Crown entity</b></p> <p>Independent Crown entities are not subject to government policy directions unless specifically provided for in another Act. Board members are appointed by the Governor-General on the advice of the Minister, and may be dismissed by the Governor-General for 'just cause', on the advice of the Minister, in consultation with the Attorney-General.</p>	Health and Disability Commissioner	Anthony Hill (Commissioner)	<p>Theodora Baker (Deputy Commissioner, Complaints Resolution)</p> <p>Lynne Lane (Mental Health Commissioner)</p> <p>Rose Wall (Deputy Commissioner, Disability)</p>	N/A
<p><b>Crown-owned company</b></p> <p>(listed under Schedule 4A to the Public Finance Act 1989)</p> <p>Crown-owned companies have the ability to have mixed commercial and non-commercial objectives (operating in a commercial manner in a public sector environment). They can have flexible ownership arrangements if desired. Directors are usually appointed by joint Ministers.</p>	Health Benefits Limited	Ted van Arkel	Dr Lester Levy [Resigned – remaining in office until 31 December 2014]	David Wood (Interim Chief Executive)

## Board appointments

The Minister appoints up to four members to each DHB board, to complement the skills and experience of the board's seven elected members. The Minister appoints each board's chair and deputy chair from among the elected and appointed members (see page 36).

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

Health Benefits Limited's chair, deputy chair and members are jointly appointed by the Minister of Health and the Minister of Finance.

Board members are typically appointed for a three-year term of office, and the Health and Disability Commissioner and Deputy Commissioners are normally appointed for five-year terms. Vacant positions can be filled by the Minister at any time.

The Minister can consider incumbents for reappointment. In some cases, enabling legislation sets out the position on reappointment and a maximum number of terms.

# Accountability and performance

Crown entities have a range of accountability documents in place to guide and monitor their performance. Crown entity performance is monitored by the Ministry on behalf of the Minister, and entities file (at a minimum) quarterly performance reports. Some additional performance and accountability measures exist for DHBs (see pages 36–41).

## Annual Letter of Expectations

The Minister of Health provides a Letter of Expectations to all health Crown entities annually. This letter sets out the Government’s strategic priorities for health, and has specific expectations for entities.

## Enduring Letter of Expectations

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

## Statement of Intent and Statement of Performance Expectations

These documents set the entity's strategic intentions and medium-term undertakings, outline how the entity’s funding will be allocated across services, and what targets and indicators will be used to measure performance. Entities are accountable to Parliament via their Statement of Intent (SOI) and Statement of Performance Expectations (SPE), and these are tabled in Parliament at the beginning of the financial year.

## Output Agreement

This is the principal relationship agreement between the Minister and each entity. It contains entity-specific agreed performance targets, as set out in the SPE. DHBs’ Output Agreements are known as Crown Funding Agreements (see page 38).

## Annual Report

This report sets out the entity’s performance in achieving the goals, indicators and targets contained in its SOI and SPE, and how the funding was actually allocated.

# Directions

## Policy directions

The Minister may give one or more Crown entities a direction on government policy relating to the entity’s functions and objectives. Crown agents must ‘give effect to’ policy directions, and autonomous Crown entities must ‘have regard to’ them. The Minister cannot give an independent Crown entity a policy direction unless this is specifically provided for in an Act. There is no ability to give a policy direction to Crown-owned companies.

## **Whole of government directions**

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

Whole of government directions can apply to categories of Crown entities (eg, all statutory entities), types of statutory entity (eg, Crown agents) or a group of entities with common characteristics (eg, DHBs, health sector Crown entities). Companies listed on Schedule 4A to the Public Finance Act 1989 (eg, Health Benefits Limited) may be included in whole of government directions.

On 22 April 2014, the Minister of State Services and the Minister of Finance issued directions to apply whole of government approaches to Procurement, ICT and Property. These directions have come into force.

## **DHB-specific directions**

The Minister has additional direction-giving powers under the NZPHD Act, in respect of DHBs (see page 41).

## **Crown agents**

### **District health boards**

There are currently 20 district health boards (DHBs). DHBs are responsible for implementing the health policies of the Government, and for providing or funding the provision of health services in their districts. See Chapter 6 for information about DHBs.

### **Health Promotion Agency**

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

HPA's role is to lead and deliver innovative, high-quality and cost-effective programmes that promote health, wellbeing and healthy lifestyles, disease prevention, and illness and injury prevention. This includes providing advice and recommendations to government, government agencies, industry, non-government bodies, communities, health professionals and others on the supply, consumption and misuse of alcohol. HPA also engages in research on the use of alcohol in New Zealand, public attitudes towards alcohol, and problems associated with alcohol misuse.

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

**Table 3: Health Promotion Agency financial forecast**

Measure	Actual (\$m)	Budget (\$m)		
	2013/14	2014/15	2015/16	2016/17
Income	33.556	25.998	25.608	25.608
Expenditure	33.552	25.598	25.608	25.608
Surplus/(deficit)	0.034	0.000	0.000	0.000
Equity	3.721	2.658	2.658	2.658

## Health Quality & Safety Commission

The Health Quality & Safety Commission (HQSC) was established in December 2010. Its objectives are to lead and coordinate work across the health and disability sector, for the purposes of monitoring and improving the quality and safety of health and disability support services.

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

**Table 4: Health Quality & Safety Commission financial forecast**

Measure	Actual (\$m)	Forecast (\$m)		
	2013/14	2014/15	2015/16	2016/17
Income	13.635	13.296	13.046	13.046
Expenditure	14.067	13.481	13.046	13.046
Surplus/(deficit)	(0.432)	(0.185)	0.000	0.000
Equity	1.344	1.494	1.494	1.494

## Health Research Council of New Zealand

The Health Research Council of New Zealand (HRC) is responsible for the allocation of the government's investment in public-good health research. HRC funds health research in four broad areas:

- health and wellbeing in New Zealand – keeping New Zealanders healthy and independent throughout life
- improving outcomes for acute and chronic conditions – better recovery for people suffering an illness or injury
- New Zealand health delivery – improving service delivery
- rangahau hauora Māori – supporting Māori health research.

**Table 5: Health Research Council financial forecast**

Measure	Actual (\$m)		Forecast (\$m)	
	2013/14	2014/15	2015/16	2016/17
Income	84.629	84.35	84.47	84.37
Expenditure	79.953	82.64	84.27	87.42
Surplus/(deficit)	4.676	1.71	0.20	(3.05)
Equity	12.795	16.27	16.47	13.42

Note: HRC is largely funded from Vote: Science and Innovation.

## New Zealand Blood Service

The New Zealand Blood Service (NZBS) ensures the supply of safe blood products. It takes responsibility for the development of an integrated national blood transfusion process, from the collection of blood from volunteer donors to the provision of blood products within the hospital environment.

**Table 6: New Zealand Blood Service financial forecast**

Measure	Actual (\$m)		Forecast (\$m)	
	2013/14	2014/15	2015/16	2016/17
Income	105.913	107.769	111.002	114.613
Expenditure	105.049	108.744	112.542	114.903
Surplus/(deficit)	0.864	(0.975)	(1.540)	(0.290)
Equity	37.111	34.257	32.717	32.427

Note: NZBS is funded through the sale of blood products to DHBs.

## Pharmaceutical Management Agency

The Pharmaceutical Management Agency (PHARMAC) decides, on behalf of DHBs, which medicines and related products are publicly funded in New Zealand and to what level. PHARMAC operates on a capped budget agreed by the Minister and DHBs. The capped pharmaceutical budget for 2014/15 is \$795 million. In addition to medicines used in the community, PHARMAC manages all hospital medicines and the vaccines funded by government. PHARMAC is also working towards the management of hospital 'medical devices' (eg, wound care products, laparoscopic equipment, thermometers), working in conjunction with Health Benefits Limited (see below).

PHARMAC's main roles include:

- managing the Combined Pharmaceutical Budget for community medicines, vaccines and hospital cancer medicines
- determining the Pharmaceutical Schedule – the list of government-funded medicines prescribed and dispensed in the community, medicines available in DHB hospitals (including pharmaceutical cancer treatments) and vaccines
- managing access to medicines for named individuals through the Named Patient Pharmaceutical Assessment policy and other special access programmes
- promoting the responsible use of medicines
- engaging in research, policy work and support to others in the health sector.

**Table 7: PHARMAC financial forecast**

Measure	Actual (\$m)	Forecast (\$m)		
	2013/14	2014/15	2015/16	2016/17
Income	24.794	23.890	28.198	28.124
Expenditure	20.775	27.655	27.708	27.941
Surplus/(deficit)	4.019	(3.765)	0.490	0.183
Equity	18.242	19.254	19.744	19.927
Retained earnings portion of equity	4.994	4.243	4.648	5.034

## Independent Crown entity

### Health and Disability Commissioner

The Health and Disability Commissioner ensures that the rights of consumers are upheld and encourages health or disability service providers to improve their performance. This includes making sure that consumer complaints are taken care of fairly and efficiently. The Commissioner also funds a national advocacy service to help consumers with complaints.

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

**Table 8: Health and Disability Commissioner financial forecast**

Measure	Actual (\$m)	Forecast (\$m)		
	2013/14	2014/15	2015/16	2016/17
Income	11.310	11.838	11.831	11.828
Expenditure	11.655	11.838	11.831	11.828
Surplus/(deficit)	(0.346)	0.000	0.000	0.000
Equity	0.737	0.542	0.542	0.542

## Crown-owned company

### Health Benefits Limited

While not a Crown entity under the Crown Entities Act, Health Benefits Limited is a Crown-owned company listed in Schedule 4A to the Public Finance Act 1989. It was formed in 2010 to facilitate and lead cost-saving initiatives for DHBs in administrative, support and procurement areas. HBL is held in equal shares by the Minister of Health and the Minister of Finance.

HBL works with DHBs to identify efficiencies and streamline back-office functions. This includes services such as financial management and information systems, procurement and supply chain, human resources, IT infrastructure and facilities management. Savings made from these activities are reinvested into frontline health services.

**Table 9: Health Benefits Limited financial forecast**

Measure	Actual (\$m)	Budget (\$m)	Forecast (\$m)	
	2013/14	2014/15	2015/16	2016/17
Income	59.92	45.36	46.36	46.36
Expenditure	58.02	47.26	46.36	46.36
Surplus/(deficit)	1.90	(1.90)	0.00	0.00
Equity	61.33	70.97	70.97	70.97

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## 6 District health boards

There are currently 20 district health boards (DHBs) in New Zealand (see Figure 3 and Table 10). DHBs are responsible for implementing the health policies of the Government, and for providing or funding the provision of health services in their districts. DHBs fund primary health organisations to provide essential primary health care services to their populations (see page 44). Public hospitals are owned and funded by DHBs (see Appendix 4 for a list of public hospitals).

The NZPHD Act created DHBs and sets out their objectives, which include:

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

Other DHB objectives include:

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

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

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

The four regions are:

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

Subsets of some regions have an enhanced working relationship, sharing key personnel, developing jointly-delivered services and sharing back-office functions like planning and funding, communications and human resources (eg, the three DHBs in the greater Wellington region – Hutt Valley, Capital & Coast and Wairarapa DHBs – through their ‘3DHB’ work programme).

Figure 4: DHB boundaries



Note: In August 2014, Cabinet agreed that responsibility for the Chatham Islands should shift from Hawke's Bay DHB to Canterbury DHB [CAB Min (14) 26/4 refers]. Work is underway to give effect to this decision.

**Table 10: DHB office holders, chief executives, populations and 2014/15 funding**

DHB	Chair (elected/appointed)	Deputy chair (elected/appointed)	Chief executive	Population	2014/15 funding
Northland	Tony Norman (appointed)	Sally Macauley (elected)	Dr Nick Chamberlain	160,615	\$485.8 million
Waitemata	Dr Lester Levy (appointed)	Tony Norman (appointed)	Dr Dale Bramley	574,495	\$1304.5 million
Auckland	Dr Lester Levy (appointed)	Dr Lee Mathias (elected)	Ailsa Claire	475,765	\$1074.6 million
Counties Manukau	Dr Lee Mathias (appointed)	Wendy Lai (appointed)	Geraint Martin	525,120	\$1242.1 million
Waikato	Bob Simcock (appointed)	Sally Christie (elected)	Dr Nigel Murray	377,335	\$991.7 million
Lakes	Deryck Shaw (appointed)	Lyall Thurston (elected)	Ron Dunham	103,175	\$277.6 million
Bay of Plenty	Sally Webb (appointed)	Ron Scott (appointed)	Phil Cammish	218,020	\$613.2 million
Tairāwhiti	David Scott (appointed)	Barbara Clarke (elected)	Jim Green	46,698	\$143.8 million
Taranaki	Pauline Lockett (appointed)	Sally Webb (appointed)	Tony Foulkes	111,030	\$301.8 million
Hawke's Bay	Kevin Atkinson (elected)	Ngahiwi Tomoana (appointed)	Dr Kevin Snee	157,470	\$434.1 million
Whanganui	Dot McKinnon (appointed)	Phil Sunderland (appointed)	Julie Patterson	62,748	\$201.6 million
MidCentral	Phil Sunderland (appointed)	Kate Joblin (appointed)	Murray Georgel	171,285	\$456.9 million
Hutt Valley	Dr Virginia Hope (appointed)	Wayne Guppy (elected)	Graham Dyer	145,835	\$354.5 million
Capital & Coast*	Dr Virginia Hope (elected)	Derek Milne (appointed)	Debbie Chin (Interim Chief Executive)	302,645	\$678.3 million
Wairarapa	Derek Milne (appointed)	Leanne Southey (appointed)	Graham Dyer	40,840	\$121.8 million
Nelson Marlborough	Jenny Black (elected)	Ian MacLennan (appointed)	Chris Fleming	143,028	\$377.3 million
West Coast	Peter Ballantyne (appointed)	[Vacant]	David Meates	33,310	\$119.1 million
Canterbury	Murray Cleverley (appointed)	Steve Wakefield (appointed)	David Meates	514,680	\$1249.6 million
South Canterbury	Murray Cleverley (elected)	Ron Luxton (elected)	Nigel Trainor	57,163	\$163.7 million
Southern*	Joe Butterfield (appointed)	Tim Ward (elected)	Carole Heatly	311,085	\$771.9 million

\* Capital & Coast and Southern DHBs also have an appointed Crown monitor. These are Dr Margaret Wilsher (Capital & Coast) and Dr Jan White (Southern).

# Shared services agencies and subsidiaries

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

- healthAlliance NZ Ltd and Northern Regional Alliance Ltd (Northern region)
- Health Share Ltd (Midland region)
- Central Region's Technical Advisory Services Ltd (CRTAS) (Central region)
- South Island Alliance (South Island region).

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

National collaboration on matters of shared interest is directed through DHB Shared Services, a division of CRTAS. A national shared services agency, Health Benefits Limited, has also been established, to reduce DHBs' costs through the efficient and effective delivery of administrative, support and procurement services.

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

## Board appointments

For each of the 20 DHB boards, seven members are elected by the community every three years (concurrently with local elections), and up to four members are appointed by the Minister. The Minister also appoints each board's chair and deputy chair from among the elected and appointed members. Should a vacancy arise, regardless of whether it is an elected or appointed position, the Minister can fill that vacancy at any time.

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

At present, a number of DHB board positions are held jointly. Such cross-appointments are made to foster greater collaboration between DHBs. For example, in the Northern Region, the Chair of Northland DHB is the Deputy Chair of Waitemata DHB, the Chair positions at Waitemata and Auckland DHBs are jointly held, and the Deputy Chair of Auckland DHB is the Chair of Counties Manukau DHB.

The Minister may appoint a Crown monitor or monitors to sit on a DHB's board if the Minister considers it desirable to do so to improve that DHB's performance. The Minister may also dismiss a DHB board and replace it with a commissioner if the Minister is seriously dissatisfied with that board's performance.

## Accountability

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

into three groups: government expectations, planning documents and accountability documents.

## **Government expectations**

The following documents set out the policies of the government of the day and the role DHBs are expected to play in implementing these policies.

### **Annual Letter of Expectations**

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

### **Enduring Letter of Expectations**

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

## **Planning documents**

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

### **Annual Plan**

Each DHB agrees with the Minister on an Annual Plan. This plan sets out the best way of delivering health services locally, regionally and nationally, and how this can be provided in a financially responsible manner and in line with the DHB's role and functions.

### **Regional Services Plan**

The Regional Services Plan identifies a set of goals for a particular region and sets out how these goals will be achieved. Collaborating regionally has the potential to increase efficiency and provide a better standard of care across a greater area than if each DHB were to act alone. The Minister approves the Regional Services Plan and regions regularly report on their plan.

### **Māori Health Plan**

Māori Health Plans provide a summary of the health needs of a DHB's Māori population, and set out the DHB's plan to meet these needs in order to reduce the health disparities between Māori and non-Māori. The plan is finalised by agreement between the DHB and the Ministry.

## **Accountability documents**

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

## **Statement of Intent**

Each DHB is required to publish a Statement of Intent (SOI) once every three years, setting out the high-level objectives and strategic focus for the next four financial years (eg, an SOI published in the 2014/15 financial year will also cover 2015/16, 2016/17 and 2017/18).

The DHB board prepares the SOI, with comment from the Minister. Once the board signs it off, the Minister tables the SOI in Parliament.

DHBs have been encouraged to include their SOI as a component of the Annual Plan in order to reduce duplication of information. The SOI component can then be extracted from the Annual Plan for tabling.

## **Statement of Performance Expectations**

DHBs include, as a component of the Annual Plan, a Statement of Performance Expectations (SPE) containing the forecast financial statements for the current year. The SPE component can also be extracted from the Annual Plan for tabling. This document also sets out non-financial performance measures against which the DHB's performance can be assessed.

The DHB board prepares the SPE, with comment from the Minister. Once the board signs it off, the Minister tables the SPE in Parliament.

## **Crown Funding Agreements**

Crown Funding Agreements (CFAs) are made between DHBs and the Minister. These set out the public funding the DHB will receive in return for providing services to its resident population. These agreements can also set out accountability requirements.

CFA variations recognise changes in funding responsibilities for services or reporting requirements. The CFA variation process has four 'omnibus' rounds in the financial year. The execution date is the date on which the variation has been signed by both parties (ie, the DHB's Chief Executive and the Director-General of Health).

## **Operational Policy Framework**

The Operational Policy Framework is a set of business rules, policies and guideline principles that outline the operating functions of DHBs. The Operational Policy Framework is incorporated as part of the CFA.

## **Annual Report**

DHBs are required to report on their performance for the year against the measures set out in their SPE and their current SOI. Other information must be included in an Annual Report, such as:

- a statement of service performance
- an annual financial statement for the DHB
- any direction given to the DHB by the Minister
- the amount of remuneration paid to DHB board members and employees in the year
- an audit report, produced on behalf of the Auditor-General.

Annual Reports must be signed off by two board members and provided to the Minister within 15 working days of the DHB receiving the audit report.

## Quality Accounts

Quality Accounts are a means by which health care providers account for the quality of the services they deliver, just as financial accounts show how an organisation uses its money. Quality Accounts are being adopted in New Zealand and are produced annually by DHBs, with guidance from the Health Quality & Safety Commission.

The accountability cycle timetable, showing how the various government expectations, planning documents and accountability documents fit together, is set out at Table 11.

**Table 11: Accountability cycle timetable**

1 February	Crown Funding Agreement variations signed by both parties (inclusion of new service schedules).
March/May	Drafts of the Annual Plan, with Statement of Intent (SOI), as required, and the Statement of Performance Expectations (SPE) and Regional Service Plan are provided to the Minister of Health (via the Ministry). The Minister provides feedback. The draft Māori Health Plan is provided to the Ministry, and feedback is provided by the Māori Health business unit.
1 May	Crown Funding Agreement variations signed by both parties (roll-overs of existing service schedules).
June	The final Annual Plan, with SOI, as required, the SPE and the Regional Service Plan are provided to the Minister for approval. The final Māori Health Plan is forwarded to the Ministry of Health for agreement. A joint approval letter from the National Health Board and the Māori Health business unit is provided to DHBs.
30 June	End of financial year.
As soon as practicable	DHBs publish the Annual Plan with SOI, as relevant, and the SPE. The Minister of Health presents the DHB SOI, as required, and the SPE to the House of Representatives. When the SOI falls due for tabling once every three years, the Minister can present the Annual Plan <sup>2</sup> containing the component SOI and the SPE, or the SOI and SPE can be presented as stand-alone documents.
1 July	Crown Funding Agreement variations signed by both parties (inclusion of new service schedules).
1 October	Crown Funding Agreement variations signed by both parties (inclusion of new service schedules).
November	DHBs must produce an Annual Report following the end of the financial year. A final, board-approved Annual Report for the preceding financial year must be provided to the Minister no later than mid-November. Draft Letter of Expectations is prepared for the Minister.
December	DHBs publish their Quality Accounts on their website and submit these to the Health Quality & Safety Commission. DHBs may wish to publish their Quality Accounts as part of their Annual Report. Minister's Letter of Expectations is sent to DHB chairs.

## Performance

In addition to performance reported on in accountability documents, DHBs' progress towards achieving financial and non-financial performance targets is reported throughout the year.

<sup>2</sup> There is no legislative requirement to present the DHB Annual Plan to the House of Representatives. However, the Minister may consider it convenient to table the Annual Plan containing the SOI and SPE components as a single document. If necessary, the SOI and SPE components can be extracted from the Annual Plan for tabling, to ensure compliance with the requirements of the Crown Entities Act.

The Ministry monitors DHB financial performance, non-financial performance, health targets and quality indicators. The Ministry uses a Monitoring and Intervention Framework (MIF) which allows it to influence DHB performance through increasingly intensive levels of monitoring and, where necessary, intervention to ensure that issues relating to poor performance are addressed.

## **Financial performance**

DHBs provide financial data from financial templates after the end of each month. The information is analysed, and net results by DHB against plan are reported to the Minister. Following this, a further report presents an overview of the DHB sector as a whole (highlighting where the sector or an individual DHB reports a significant variance against plan, or against comparable performance within the sector). Interpretation of the data provided by DHBs enables areas of financial pressure and risks, as well as best practice within the DHB sector.

## **Non-financial performance**

### **Health targets**

Health targets are a set of national performance measures designed to improve the performance of health services that reflect significant public and Government priorities. There are currently six health targets: three focus on patient access (Shorter stays in emergency departments; Improved access to elective surgery; Shorter waits for cancer treatment) and three focus on prevention (Increased immunisation; Better help for smokers to quit; More heart and diabetes checks). The health targets are reviewed annually to ensure they align with current health priorities. DHBs report their progress to the Ministry four times a year, as at 30 September, 31 December, 31 March and 30 June. In turn, the Ministry reports its results to the Minister and the public.

The current health targets and DHBs' results are on the Ministry's website ([www.health.govt.nz/new-zealand-health-system/health-targets](http://www.health.govt.nz/new-zealand-health-system/health-targets)).

### **Quarterly summaries**

Quarterly summary reports provide an overview of DHB performance against expectations agreed in DHB Annual Plans and Regional Service Plans. The report is presented using a consolidated dashboard approach, showing an at-a-glance snapshot of DHB performance issues as at 30 September, 31 December, 31 March and 30 June.

### **Patient experience survey**

The patient experience survey enables patients to provide feedback that can be used to monitor and improve the quality and safety of health services. Capturing, understanding and acting on patient experiences, in a timely manner, provides a vital contribution to improving health service delivery and to prioritising attention and resources.

DHBs are expected to survey adult inpatients' (ie, inpatients aged 15 and older) experience of the care they received and to take part in a national review facilitated by the Health Quality & Safety Commission (HQSC). This review assesses ways to collect information about patient experience and makes recommendations for future data collection strategies.

The first national inpatient survey reports are due from DHBs on 20 October 2014. It is mandatory for DHBs to participate in quarterly surveys from 1 July 2014. However, the national survey and reporting system enables DHBs to conduct fortnightly surveys if they choose.

An annual evaluation will be undertaken by HQSC. As part of this, all system users will be surveyed on their experience with the tools, how the system is being used and outcomes at DHB and national level. The evaluators will then analyse the results and report to HQSC, DHBs and the national system provider. At this time, HQSC will identify how the programme could be enhanced to lead to better patient safety and quality of health service delivery.

## DHB-specific directions

In addition to the policy direction and whole of government direction provisions in the Crown Entities Act 2004 (see page 27), under the NZPHD Act the Minister can:

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

## Funding and services

DHBs exist within a funding environment where:

- there is a mix of funding models (ie, capitation, fee-for-service, pay-for-performance and individualised funding), and a range of financial and non-financial incentives – the Ministry also contracts directly with providers of some services, such as disability support and some maternity services
- a population-based funding formula (PBFF) determines the share of funding to be allocated to each DHB, based on the population living in the district – the formula includes adjustors for population age, sex, relative measures of deprivation status and ethnicity
- DHBs are responsible for making decisions on the mix, level and quality of health and disability services, within the parameters of national strategies and nationwide minimum service coverage and safety standards
- the Ministry, as the Minister's agent, defines nationwide service coverage, safety standards and the operating environment – the Minister enters into funding agreements with DHBs and may exercise reserve powers in the case of repeated performance failure (ie, appointing a Crown monitor to, or dismissing, the DHB board; see page 36).

DHB funding (\$11.405 billion in 2014/15) is distributed using PBFF, which allocates funding based on the size and composition of each DHB's population. This means the share of funding each DHB receives is largely determined by whether (and by how much) its population is growing or shrinking relative to others. Statistics New Zealand provides updated DHB populations annually for use in setting DHB funding shares.

Each year DHBs' (and the Ministry's non-departmental expenditure) budgets are adjusted using 'contribution to cost pressures' (CCP) and demographic (demo) adjustors. These aim to accommodate inflationary pressures and service demand pressures caused by population changes. CCP and demo funding adjustments are aimed at maintaining per capita service coverage and quality. Where the scope of services is increased, rather than just maintained, this is generally funded separately via new initiatives money, on top of the CCP and demo increases.

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

The Service Coverage Schedule outlines the national minimum range and standard of health and disability services to be publicly funded, and DHBs are required to ensure their populations have access to all these services. DHBs may provide the services directly or contract with third parties. A DHB may also purchase certain specified services for their population from another DHB using a system known as 'inter-district flows'. Where these services are provided by another DHB, a national agreed price is generally used or DHBs may agree on local arrangements between themselves.

DHBs pay an additional lump sum to the tertiary hospitals to compensate them for the higher costs of maintaining specialist tertiary capability and access. The national prices for inter-district flows and the tertiary adjuster are calculated annually in a joint project between the Ministry and DHBs. As part of the funding advice to DHBs, the Ministry will provide further advice on pricing for the 2015/16 year.

## **Employment relations**

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

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

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

### **Role of the Ministry in employment relations**

Under the NZPHD Act, DHB chief executives must consult with the Director-General of Health before finalising the terms and conditions of a collective agreement. These obligations are explained further by specific Ministry guidelines, the Operational Policy Framework and the Government Expectations for Pay and Employment Conditions in the State Sector.

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

- monitor local, regional and national bargaining
- liaise with and provide information, advice and feedback to the Minister of Health and the Minister of State Services, other government agencies and DHBs on employment relations activities and risks
- advise and report to the Committee of Ministers for State Sector Employment Relations.

## **Health Sector Relationship Agreement**

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

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# 7 Other office holders, organisations and networks

## Statutory officers

### Public health statutory officers

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

### Mental health statutory officers

Directors of area mental health services are employed by and function within DHBs. They are responsible for the day-to-day operation of the Mental Health (Compulsory Assessment and Treatment) Act 1992. They are appointed by the Director-General of Health and must report to the Director of Mental Health every three months on the exercise of their powers, duties and functions. There are 23 directors of area mental health services.

The Minister appoints district inspectors under section 94 of the Act to monitor compliance with the compulsory assessment and treatment process. District inspectors work to protect the rights of patients, address concerns of whānau and investigate alleged breaches of patient rights, as set out in the Act. There are currently 38 district inspectors.

### Other statutory officers

The Director-General also appoints statutory officers under a range of other acts, in particular the Smoke-free Environments Act 1990, the Tuberculosis Act 1948, the Biosecurity Act 1993, the Psychoactive Substances Act 2013, and the Hazardous Substances and New Organisms Act 1996. City and district councils also appoint environmental health officers under the Health Act, who assist councils to perform their environmental health functions under the Act.

## Primary health organisations

Primary health organisations (PHOs) are funded by DHBs to ensure the provision of essential primary health care services to those people who are enrolled with a general practice. As at October 2014 there are 32 PHOs, which vary widely in size and structure. All PHOs are not-for-profit organisations.

A PHO provides primary health services either directly or through its provider members. These services are designed to improve and maintain the health of the enrolled PHO population, as well as having the responsibility for ensuring that services are provided in the community to restore people's health when they are unwell. The aim is to ensure GP services are better linked with other health services to ensure a seamless continuum of care.

## **PHO performance – Integrated Performance and Incentive Framework**

The Integrated Performance and Incentive Framework has been developed to support the health system to address equity, safety, quality, access and cost of services. It is a quality and performance improvement programme that will reward good performance individually, at a provider level, and collectively at an alliance level. The Framework will be developed and implemented in phases over several years.

An expert advisory group from the sector was established in late 2012 to guide this work. The group's report describes a proposed Framework that, while initially concentrating on the performance relationships between primary care and DHBs, can be expanded to include the broader health system as it matures over time.

Phase 1 of the Framework commenced on 1 July 2014 with the implementation of the following measures:

- more heart and diabetes checks (target 90 percent of the relevant enrolled population)
- better help for smokers to quit (target 90 percent)
- increased immunisation rates at eight months old (target 95 percent)
- increased immunisation rates at two years old (target 95 percent)
- cervical screening coverage (target 80 percent).

All PHOs are expected to meet the national target performance by 30 June 2015. Quarterly targets will be set for individual organisations to enable them to reach the national targets after four quarters.

Further co-development of governance, measures, incentives, change management, alliance support and business improvement/audit is underway.

## **Health alliances**

Alliances are local partnerships between health providers, organisations and funders. Since 2013, all DHBs and PHOs must form an alliance under the District Alliance Agreement. Effective alliances are dependent on mature relationships at a local level.

Alliances provide a high trust forum for service development that reflects shared responsibility for a whole of system approach. While alliances are initially between DHBs and PHOs, other service providers will be included as the scope of each alliance's service development broadens.

# Accident Compensation Corporation

The Accident Compensation Corporation (ACC) provides no-fault personal injury cover for New Zealand residents and visitors. ACC can provide financial support for medical treatment, rehabilitation, loss of income and other ongoing costs. It is funded via levies on people's incomes, businesses, petrol and vehicle registration, and through the Crown's budget collected via taxes. ACC contracts with healthcare providers to provide services. When treatment is covered, healthcare providers are paid directly by ACC, occasionally with an additional top-up payment from the consumer.

## National Ambulance Sector Office

The National Ambulance Sector Office is a joint office between ACC and the Ministry. The Office's functions are to:

- progress the New Zealand Ambulance Service Strategy
- provide a single voice for the Crown on strategic and operational matters regarding emergency ambulance services
- manage and monitor funding and contracts from both agencies related to the delivery of emergency ambulance services.

## Non-government organisations

Non-government organisations (NGOs) receive significant funding – in the order of \$2–4 billion per year – from both the Ministry and DHBs. Many NGOs are non-profit, and along with providing services to consumers they are a valuable source of expertise, intelligence and influence at a community level.

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

The Ministry and NGOs have a formal relationship outlined in the Framework for Relations between the Ministry of Health and Health and Disability Non-governmental Organisations. To facilitate this relationship, there is an NGO Health & Disability Council and within the Ministry, an NGO relationship management role.

## Public health units

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

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

Responsibility for food safety sits with the Ministry for Primary Industries, although public health units take the lead in investigating outbreaks of food-borne illness.

## **Local authorities**

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

Core local government activities that promote public health include resource management, the provision of drainage, sewerage works, drinking water, recreation facilities and areas and refuse collection.

## **Clinical networks**

Clinical networks increase connectivity across the health sector and are a significant feature of our health system. There are a number of key networks of clinicians working together to improve the quality of health services.

### **Major Trauma National Clinical Network**

The Major Trauma National Clinical Network was established in 2012 to ensure the very best level of care is provided consistently across New Zealand to severely injured people. It is a joint initiative between ACC and the Ministry.

Since its establishment this Network has implemented a structured approach to delivering high-quality trauma care, which ensures that injured patients throughout New Zealand are managed appropriately wherever they receive their care. There is also a minimum data set now in place for a national major trauma registry, to enable a consistent baseline data collection that will inform ongoing guideline development and quality improvement.

This Network brings together DHBs and all service providers to work effectively together, reducing duplication and wastage of resources.

This Network's Clinical Leader is Associate Professor Ian Civil.

### **National Diabetes Service Improvement Group**

The National Diabetes Service Improvement Group is a Ministry-funded group of experts, that also includes consumer representatives. The Improvement Group has key work streams looking at:

- prevention and pre-diabetes
- complications of diabetes
- patients with Type1 diabetes, children and young people
- inpatients with diabetes
- workforce requirements and development
- health system performance

- self-management.

The Improvement Group is chaired by Dr Paul Drury.

## **National Renal Transplant Leadership Team**

The National Renal Transplant Leadership Team has recently been established, to oversee the implementation of national initiatives to increase renal transplantation volumes. The Leadership Team will contribute to the integration of all clinical services for people with renal disease by working closely with the National Renal Advisory Board.

The Leadership Team is led by Dr Nick Ross.

## **National Stroke Network**

The National Stroke Network's objective is to facilitate equitable access and improve outcomes for stroke survivors and their families, through the implementation of best practice set out in the New Zealand Clinical Guidelines for Stroke Management 2010.

This Network aims to support DHBs through the four regional stroke networks to:

- integrate care for patients experiencing stroke, ensuring equitable access to care in community, primary and secondary care settings
- ensure DHBs' systems and processes support the current national stroke indicators.

This Network is made up of a multidisciplinary group of health professionals, including a number of stroke specialists, representing DHBs from across New Zealand.

This Network is chaired by Dr Anna Ranta.

## **New Zealand Cardiac Network**

The New Zealand Cardiac Network provides national leadership across the cardiac continuum of care, facilitates and encourages communication between stakeholders, and supports regional networks in achieving their specific goals.

Since its inception in 2011, this Network has worked to actively encourage discussion and sharing of clinical best practice, and the exchange of ideas and potential solutions to issues common across cardiac care. To achieve this, it has worked to:

- reduce national variation in 'door to catheter' time for acute coronary syndrome patients and achieve an overall significant reduction in waiting times
- develop and implement registries that capture a wide range of measures in interventional cardiology and surgical measures, and identify opportunities for service improvement and benchmarking of DHBs
- introduce accelerated chest pain pathways in DHBs across New Zealand during 2014/15.

This Network comprises representatives from the National Cardiac Surgery Clinical Network and the four regional cardiac networks, and also includes membership from the Cardiac Society, NZ Heart Foundation, primary health care and the Ministry.

This Network is chaired by Professor Ralph Stewart.

## **National Cardiac Surgery Clinical Network**

When the National Cardiac Surgery Clinical Network was formed in 2009, New Zealanders needing cardiac surgery faced lengthy and distressing delays. This Network's objective is to lead and oversee a reform of New Zealand's cardiac surgical system and improve the delivery of cardiac surgery in New Zealand.

Since its introduction, this Network – led by cardiac surgeons, cardiologists, GPs, nurses and other health professionals – has continued to make gains and improve cardiac services. Significant progress has been made in increasing the volume of cardiac surgery operations, improving the geographical equity of cardiac surgery provision, enhancing the effectiveness of clinical prioritisation, and reducing the number of patients waiting for surgery.

This Network is chaired by Mr Harsh Singh.

## **Adolescent and Young Adult Cancer Network Aotearoa**

The Adolescent and Young Adult Cancer Network Aotearoa (AYA Cancer Network) is a membership organisation that connects hands-on health professionals and support providers from many disciplines. It was established to focus on improving outcomes and to meet the unique needs of those aged 12 to 24 years.

As part of the AYA Cancer Network, a national clinical lead role is being established. The potential work programme for the clinical lead is AYA cancer service improvement through the use of integrated patient pathways, common clinical policies and shared clinical audit programmes to ensure national consistency and clinical engagement in service planning.

## **National Child Cancer Network**

The National Child Cancer Network brings together health professionals, carers and stakeholder organisations to work collaboratively across child cancer services in New Zealand. This Network's focus is for children with cancer to receive the same quality of care regardless of who they are or where they live in New Zealand.

This Network:

- shares information, knowledge and best practice across the country
- provides advice, recommendations and action plans on specific areas of service delivery (eg, fertility preservation) through working groups.

This Network's clinical leader is Dr Scott Macfarlane.

## **Regional cancer networks**

The four regional cancer networks were established in 2006 to work across organisational boundaries, to promote a collaborative approach to service planning and delivery. The networks take a proactive leadership, facilitation and coordination approach, to ensure all providers of cancer care in the network area work together with the community to deliver the objectives of the National Cancer Programme.

The four regional networks relate to DHB geographical coverage areas and patient flows to regional cancer centres, as outlined below.

- The Northern Cancer Network is led by Dr Richard Sullivan, and covers Northland, Waitemata, Auckland and Counties Manukau DHBs.
- The Midland Cancer Network is led by Dr Humphrey Pullon, and covers Waikato, Lakes, Bay of Plenty and Tairāwhiti DHBs.
- The Central Cancer Network is led by Dr Audrey Fenton and Dr Bart Baker, and covers Taranaki, Hawke's Bay, Whanganui, MidCentral, Hutt Valley, Capital & Coast and Wairarapa DHBs.
- The Southern Cancer Network is led by Dr Shaun Costello, and covers Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern DHBs.

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# 8 International links

The Ministry maintains active links with international health organisations and other health ministries, in order to:

- protect New Zealand against international health threats
- learn from other countries' experiences and international debate on ways to organise, manage and deliver health services, including best practice and innovations
- provide support and assistance to less developed countries, particularly in the Pacific region, recognising that health in Pacific nations strongly affects the health of people in New Zealand.

## International contacts

### World Health Organization

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

New Zealand also maintains links with the Organisation for Economic Cooperation and Development, Asia–Pacific Economic Cooperation, the Commonwealth Fund (an NGO based in Washington that conducts comparative health policy research), and other regional and global organisations.

Ministers of Health are invited to attend a range of health forums across international organisations, including the World Health Assembly (the annual WHO health forum, held each May in Geneva, Switzerland).

### The Commonwealth

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

### Australia

Meetings with Australian Ministers of Health are held around three times a year, under the auspices of the Council of Australian Governments Health Council (CHC). CHC is made up of the Commonwealth Minister of Health, Health Ministers from the seven states and territories in Australia, and the New Zealand Minister of Health. New Zealand has been a member of CHC since the 1970s.

Benefits of New Zealand's involvement in CHC include the opportunity to network among peers; to observe health system development and reform in our nearest and biggest neighbour; and to learn from these opportunities, provide a New Zealand position, and influence decisions in areas of mutual interest.

The CHC is supported by the Australian Health Ministers' Advisory Council. The New Zealand Director-General of Health participates in Advisory Council meetings.

## **Pacific links**

Pacific Health Ministers meet every two years to consider regional initiatives and collaborate on existing or emerging health issues. The biennial meeting is hosted by WHO and the Secretariat of the Pacific Community. New Zealand and Australia are invited as observers to the meetings. The next meeting will be in mid-2015 in a Pacific country to be confirmed.

In addition to these ministerial meetings, there are frequent contacts at officer level between the Ministry and its Pacific counterparts, often concerning requests for technical advice.

## **International conventions**

New Zealand is party to two international treaties that specifically relate to health, and these are outlined below. There are also several other treaties that New Zealand is party to that have implications for health and disability; for example, treaties concerning the rights of children, women, migrant workers and people with disabilities.

### **WHO Framework Convention on Tobacco Control**

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

### **International Health Regulations**

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

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

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# Appendix 1: Legal and regulatory framework

## Legislation the Ministry administers

The Ministry administers a wide range of acts, regulations and other legislative instruments such as orders-in-council. The following is a brief description of the principal acts administered by the Ministry.

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<b>Alcoholism and Drug Addiction Act 1966</b>	provides for the care and treatment of people with alcohol and drug addictions.
<b>Burial and Cremation Act 1964</b>	outlines the law relating to the burial and cremation of the dead.
<b>Cancer Registry Act 1993</b>	provides for the compilation of a statistical record of the incidence of cancer in its various forms, as a basis for better direction of programmes for research and for cancer prevention.
<b>Children’s Health Camps Board Dissolution Act 1999</b>	dissolves the Children’s Health Camps Board, transfers its assets to a foundation incorporated under Part 2 of the Charitable Trusts Act 1957 and provides for incidental matters.
<b>Disabled Persons Community Welfare Act 1975, Part 2A</b>	sets out the right of people in residential care to a review of the adequacy of any disability services, and whether or not a person’s disability service needs are appropriately met by the residential care received.
<b>Epidemic Preparedness Act 2006</b>	provides statutory power for government agencies to prevent and respond to the outbreak of epidemics in New Zealand, and to respond to particular possible consequences of epidemics (whether occurring in New Zealand or overseas). This Act also aims to ensure that certain activities can continue during an epidemic in New Zealand, and to enable the relaxation of some statutory requirements that might not be capable of being complied with, or complied with fully, during an epidemic.
<b>Health Act 1956</b>	sets out the roles and responsibilities of individuals to safeguard public health, including the Minister of Health, the Director of Public Health and designated officers for public health. It contains provisions for environmental health, infectious diseases, health emergencies and the National Cervical Screening Programme.
<b>Health and Disability Commissioner Act 1994</b>	aims to promote and protect the rights of health consumers and disability service consumers to secure fair, simple, speedy and efficient resolution of complaints. It provides for the appointment of a Health and Disability Commissioner to investigate complaints, and defines the Commissioner’s functions and powers. It also provides for the establishment of a Health and Disability Services Consumer Advocacy Service, and for the promulgation of a Code of Health and Disability Services Consumers’ Rights.
<b>Health and Disability Services (Safety) Act 2001</b>	promotes the safe provision of health and disability services to the public, and establishes consistent and reasonable standards of service for providers.
<b>Health Benefits (Reciprocity with Australia) Act 1999</b>	provides for reciprocity with Australia in relation to pharmaceutical, hospital and maternity benefits.

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<b>Health Benefits (Reciprocity with the United Kingdom) Act 1982</b>	provides for reciprocity with the United Kingdom in relation to medical, hospital and related benefits.
<b>Health Practitioners Competence Assurance Act 2003</b>	aims to ensure health practitioners are competent and fit to practise their professions. It provides for: <ul style="list-style-type: none"> <li>(a) a consistent accountability regime for all health professions</li> <li>(b) the determination of the scope of practice within which each health practitioner is competent</li> <li>(c) systems to ensure that no health practitioner practises outside his or her scope of practice</li> <li>(d) power to restrict specified activities to particular classes of health practitioner</li> <li>(e) certain protections for health practitioners who take part in protected quality assurance activities.</li> </ul>
<b>Health Research Council Act 1990</b>	defines the functions and powers of the Health Research Council of New Zealand, a Crown entity responsible for managing government's investment in health research.
<b>Health Sector (Transfers) Act 1993</b>	governs the sale or transfer of assets, liabilities or functions from DHBs and certain health Crown entities to the Crown or other specified bodies.
<b>Human Tissue Act 2008</b>	governs the collection and use of human tissue to ensure that this is done in an appropriate way, without endangering the health and safety of members of the public, and that it does not involve payment.
<b>Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003</b>	provides for the compulsory care and rehabilitation of individuals with an intellectual disability who have been charged with, or convicted of, an imprisonable offence.
<b>Medicines Act 1981</b>	covers the law relating to the manufacture, sale and supply of medicines, medical devices and related products.
<b>Mental Health (Compulsory Assessment and Treatment) Act 1992</b>	defines the circumstances and conditions under which people may be subjected to compulsory psychiatric assessment and treatment. It defines and protects the rights of such people, and generally defines the law relating to the assessment and treatment of people suffering from mental disorders.
<b>Misuse of Drugs Act 1975</b>	aims to prevent the misuse of drugs.
<b>New Zealand Council for Postgraduate Medical Education Act Repeal Act 1990</b>	dissolves the New Zealand Council for Postgraduate Medical Education and repeals the New Zealand Council for Postgraduate Medical Education Act 1978.
<b>New Zealand Public Health and Disability Act 2000</b>	establishes the structure underlying public sector funding and the organisation of health and disability services. It establishes DHBs and certain health Crown entities, and sets out the duties and roles of key participants, including the Minister of Health and ministerial advisory committees.
<b>Psychoactive Substances Act 2013</b>	regulates the importation, manufacture and supply of psychoactive substances in New Zealand to protect the health of, and minimise harm to, individuals who use psychoactive substances.
<b>Radiation Protection Act 1965</b>	consolidates and amends the Radioactive Substances Act 1949, and regulates the management of radioactive materials and irradiating apparatus.

<b>Sleepover Wages (Settlement) Act 2011</b>	<p>aims to:</p> <ul style="list-style-type: none"> <li>(a) facilitate the settlement of civil proceedings between certain parties about the payment of wages at the minimum rate prescribed under the Minimum Wage Act 1983 to employees who are allowed by their employer to sleep overnight at their workplace while on duty</li> <li>(b) provide for a staged progression towards full compliance with the Minimum Wage Act 1983 in respect of the wages payable to certain employees who perform sleepovers</li> <li>(c) provide a mechanism for extending the application of subparts 1 and 2 of Part 2 to other employers that are funded through a Vote and to those employers' employees to enable, among other things, disputes that involve the same, or substantially the same, issue as that described in paragraph (a) to be settled.</li> </ul> <p>This Act has a sunset provision and is due to expire on 18 October 2016. While the Act is still alive at the moment, the Ministry is not looking to recommend any more orders-in-council under the Act as, to the Ministry's knowledge, all eligible employers who needed an order have gone through the process.</p>
<b>Smoke-free Environments Act 1990</b>	<p>aims to:</p> <ul style="list-style-type: none"> <li>(a) reduce the exposure of people who do not themselves smoke to any detrimental effect on their health caused by others' smoking</li> <li>(b) regulate the marketing, advertising and promotion of tobacco products, whether directly or through the sponsoring of other products, services or events</li> <li>(c) monitor and regulate the presence of harmful constituents in tobacco products and tobacco smoke.</li> </ul>
<b>Tuberculosis Act 1948</b>	<p>provides for the treatment, care and assistance of people who are suffering or have suffered from tuberculosis, and for preventing the spread of tuberculosis.</p>

## Other regulatory roles and obligations

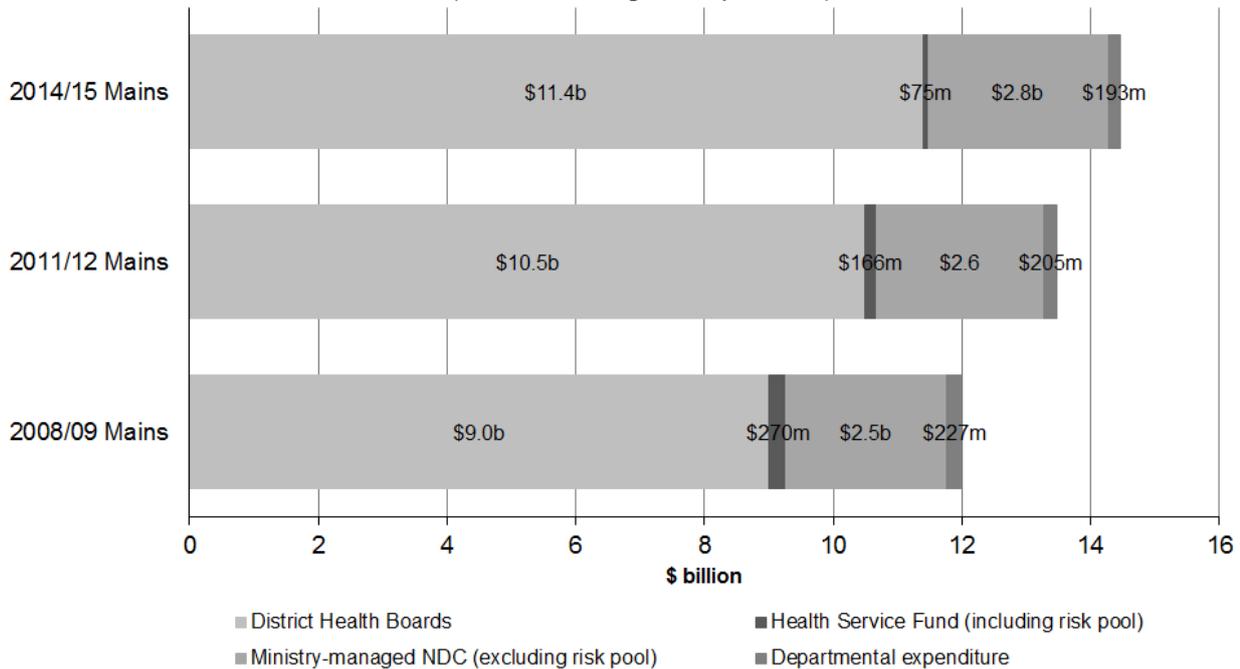
In addition to administering legislation, key personnel within the Ministry (such as the Directors of Public Health and Mental Health) have specific statutory powers and functions under various pieces of legislation.

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

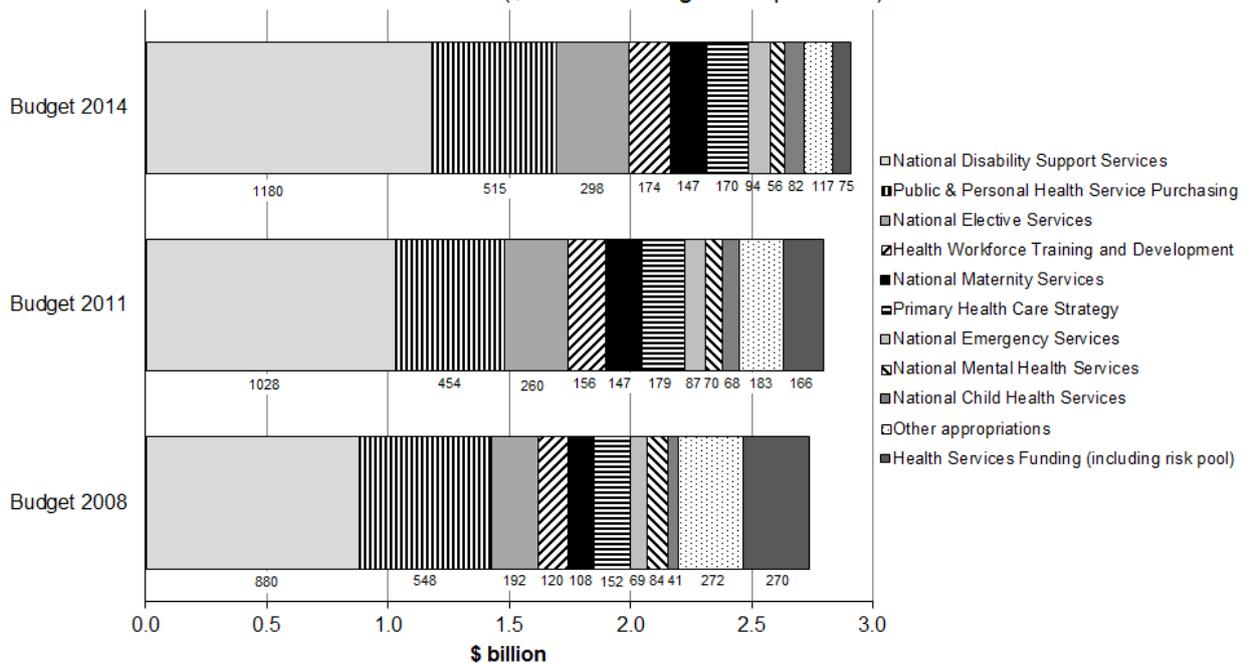
- Biosecurity Act 1993
- Civil Defence Emergency Management Act 2002
- Education Act 1989
- Gambling Act 2003
- Hazardous Substances and New Organisms Act 1996
- Human Assisted Reproductive Technology Act 2004
- Litter Act 1979
- Local Government Act 1974
- Local Government Act 2002
- Maritime Security Act 2004
- Prostitution Reform Act 2003
- Sale and Supply of Liquor Act 2012
- Social Security Act 1964
- Victims' Rights Act 2002
- Waste Minimisation Act 2008.

# Appendix 2: Vote Health

**Components of Vote Health operating expenditure (excludes capital)**  
(\$ million of budgeted expenditure)



**Components of Ministry-managed non-departmental operating expenditure**  
(\$ million of budgeted expenditure)



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# Appendix 3: Other statutory bodies, committees and office holders

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

## Health Act 1956

### National Kaitiaki Group

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

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

### National Cervical Screening Programme review committee

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

## Health Practitioners Competence Assurance Act 2003

### Responsible authorities

There are currently 16 responsible authorities under the Health Practitioners Competence Assurance Act 2003:

- Chiropractic Board
- Dental Council
- Dietitians Board
- Medical Council
- Medical Radiation Technologists Board
- Medical Sciences Council

- Midwifery Council
- Nursing Council
- Occupational Therapy Board
- Optometrists and Dispensing Opticians Board
- Osteopathic Council
- Pharmacy Council
- Physiotherapy Board
- Podiatrists Board
- Psychologists Board
- Psychotherapists Board.

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

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

The Minister appoints a mix of health practitioners and laypersons to each board/council, but each the chair and deputy chair are elected from among each board's/council's members. The Minister is able to make regulations so that a proportion of the health professional members of an authority are elected by members of the profession. Such regulations have been made with respect to the Medical Council and the Nursing Council.

## **Health Practitioners Disciplinary Tribunal**

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

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

# **Human Assisted Reproductive Technology Act 2004**

## **Ethics Committee on Assisted Reproductive Technology**

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

- considering and determining applications for assisted reproductive procedures, extending the storage period of gametes and embryos, and human reproductive research

- keeping under review any approvals previously given, and monitoring the progress of any assisted reproductive procedures performed or any human reproductive research conducted under current approvals
- any other functions the Minister assigns to it.

## **Advisory Committee on Assisted Reproductive Technology**

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

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

## **Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003**

### **District inspectors**

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

## **Medicines Act 1981**

### **Medicines Adverse Reactions Committee**

The Medicines Adverse Reactions Committee (MARC) advises the Minister on the safety of approved medicines. MARC's functions are to:

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

## **Medicines Assessment Advisory Committee**

The Medicines Assessment Advisory Committee (MAAC) provides advice to the Minister on the benefits and risks of new medicines. MAAC's functions are to:

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

## **Medicines Classification Committee**

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

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

## **Medicines Review Committee**

The Medicines Review Committee's functions are to:

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

# **Mental Health (Compulsory Assessment and Treatment) Act 1992**

## **Mental Health Review Tribunal**

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

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

released from compulsory status, the patient is able to apply to the Tribunal for a review of his or her condition. The patient can appeal a Tribunal decision to the District Court or High Court.

## **District inspectors for mental health**

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

## **Misuse of Drugs Act 1975**

### **Expert Advisory Committee on Drugs**

The Expert Advisory Committee on Drugs:

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

## **New Zealand Public Health and Disability Act 2000**

### **Cancer Control New Zealand**

Established under section 11 of the NZPHD Act, Cancer Control New Zealand provides an independent, sustainable focus for cancer control. Cancer Control New Zealand leads the sector in horizon scanning for future trends, thereby helping to reduce the incidence and impact of cancer, evaluate system effectiveness, reduce inequalities and promote research with respect to cancer. Cancer Control New Zealand provides advice and recommendations to the Minister.

### **Health and Disability Ethics Committees**

The Health and Disability Ethics Committees are a group of four regionally focused ethics committees (ie, Northern A, Northern B, Central and Southern), established under section 11 of the NZPHD Act. Their purpose is to check that health and disability research (such as clinical trials) meets or exceeds ethical standards established by the National Ethics Advisory Committee.

## **National Ethics Advisory Committee**

The National Ethics Advisory Committee is established under section 16 of the NZPHD Act. Its purpose is to:

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

## **Psychoactive Substances Act 2013**

### **Psychoactive Substances Appeals Committee**

The function of the Psychoactive Substances Appeals Committee is to determine appeals against decisions of the Psychoactive Substances Regulatory Authority made by or under the Act.

### **Psychoactive Substances Expert Advisory Committee**

The function of the Psychoactive Substances Expert Advisory Committee is to evaluate, with regard to trials, and advise the Psychoactive Substances Regulatory Authority on approval for use of psychoactive products.

## **Radiation Protection Act 1965**

### **Radiation Protection Advisory Council**

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

# Appendix 4: Public hospitals in New Zealand

Below are the public hospitals in New Zealand, listed by DHB area.

<b>DHB</b>	<b>Public hospitals</b>
Northland	Bay of Islands Hospital Dargaville Hospital Kaitaia Hospital Whangarei Hospital
Waitemata	Elective Surgery Centre North Shore Hospital Waitakere Hospital Wilson Centre
Auckland	Auckland City Hospital Buchanan Rehabilitation Centre Fraser McDonald Unit Greenlane Clinical Centre Mason Clinic Pitman House Rehab Plus Starship Child and Family Unit Te Whetu Tawera
Counties Manukau	Auckland Spinal Rehabilitation and Tamaki Oranga Botany Downs Hospital Franklin Memorial Hospital Manukau Surgery Centre Middlemore Hospital Papakura Obstetric Hospital Pukekohe Hospital
Waikato	Henry Rongomau Bennett Centre Matariki Hospital Puna Whiti Rhoda Read Hospital Taumarunui Hospital and Family Health Team Te Kuiti Hospital and Family Health Team Thames Hospital Tokoroa Hospital Waikato Hospital
Lakes	Rotorua Hospital Taupo Hospital
Bay of Plenty	Opotiki Health Care Centre Tauranga Hospital Whakatane Hospital
Tairāwhiti	Gisborne Hospital

<b>DHB</b>	<b>Public hospitals</b>
Taranaki	Hawera Hospital Taranaki Base Hospital
Hawke's Bay	Central Hawke's Bay Health Centre Chatham Island Health Centre Hawke's Bay Hospital Napier Health Centre Wairoa Hospital & Health Centre
Whanganui	Whanganui Hospital
MidCentral	Horowhenua Health Centre Palmerston North Hospital
Hutt Valley	Hutt Valley Hospital
Capital & Coast	Kapiti Health Centre Kenepuru Hospital Porirua Hospital Campus (Mental Health Services) Wellington Hospital Wellington Hospital (Mental Health Services)
Wairarapa	Wairarapa Hospital
Nelson Marlborough	Alexandra Hospital Mental Health Admissions Unit Murchison Hospital and Health Centre Nelson Hospital Tipahi Street Mental Health Wairau Hospital
West Coast	Buller Health Grey Base Hospital Reefton Health Services
Canterbury	Ashburton Hospital Burwood Hospital Christchurch Hospital Christchurch Women's Hospital Darfield Hospital Ellesmere Hospital Hillmorton Hospital Kaikoura Hospital Lincoln Maternity Hospital Oxford Hospital Rangiora Hospital The Princess Margaret Hospital Tuarangi Home Waikari Hospital
South Canterbury	Timaru Hospital
Southern	Dunedin Hospital Lakes District Hospital Southland Hospital Wakari Hospital