



MANATŪ HAUORA

**The New Zealand Health  
and Disability System:  
Organisations and  
Responsibilities**  
Briefing to the Minister of Health

November 2008

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## **Introduction: About this Paper**

This document contains an overview of the health and disability system (the system). It describes the major organisations and structures in the system, key players, and their roles, functions and legislative duties and responsibilities.

It, takes a particular focus on the roles of the Minister of Health and the Ministry of Health, and was developed to support the transition of the incoming Minister of Health (the Minister) after the 2008 general election.

# Health and Disability System Overview

A healthy population, able to participate actively in all aspects of New Zealand life, underpins a vibrant community and country. Health and participation are a foundation for engagement in community, sport and cultural activities, and maximise New Zealand's ability to grow a strong economy. A well functioning and efficient health and disability system is a vital contributor to the health status and participation rates of New Zealanders. Therefore, each New Zealander has an interest in the system and the government is ultimately responsible and accountable for its effectiveness.

## A complex system, working together

Health and disability services are delivered by a complex system of dispersed and specialised organisations and people. The players in the system have different histories, interests and connections. To function effectively all of us must be willing and able to work together across the system to ensure coherence, consistency and sustainability.

Most of the day-to-day business of the system, and around three quarters of the funding, is administered by District Health Boards (DHBs). Under this devolved system DHBs plan, manage, provide and purchase services for the population of their district. This includes funding for primary care, public health services, aged care services and services provided by other non-governmental health providers including Māori and Pacific providers.

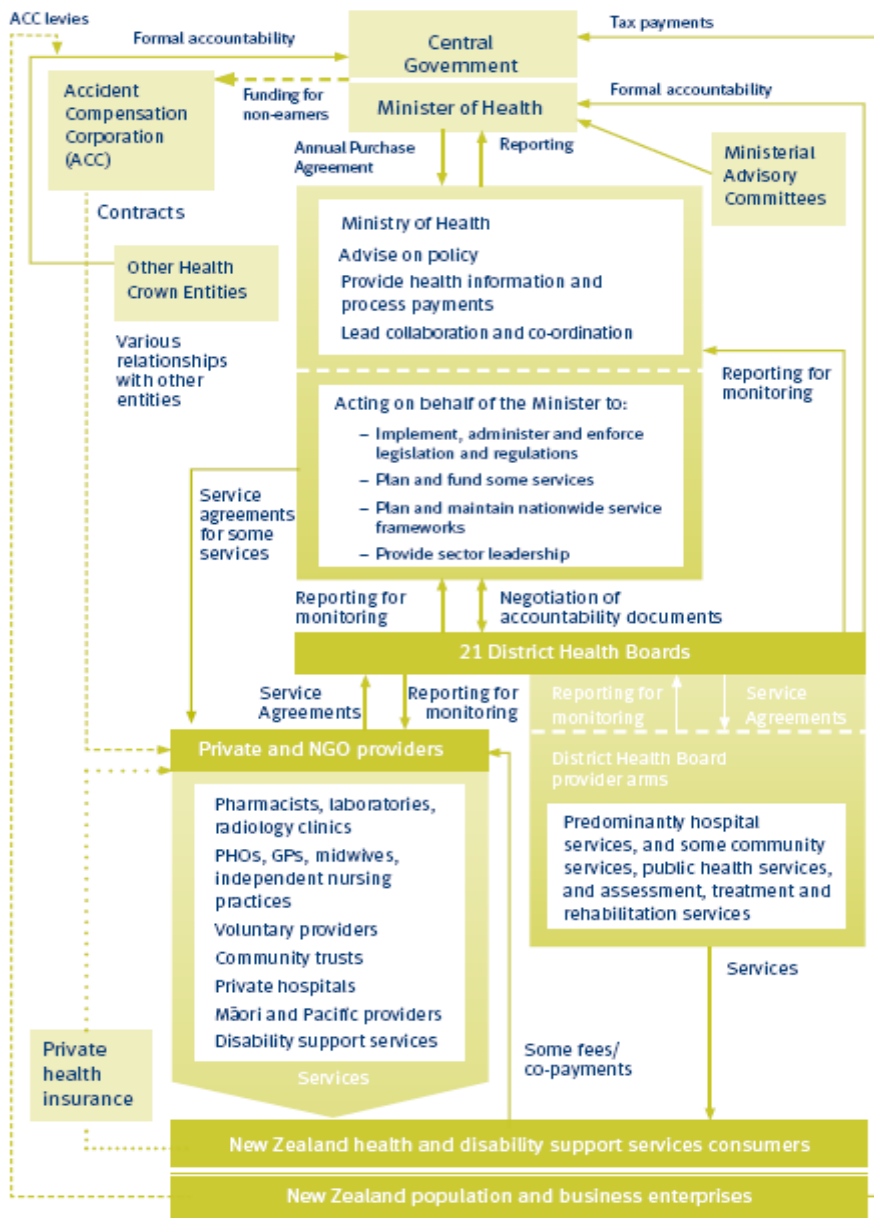
The Ministry of Health (the Ministry) has a range of roles in the system in addition to being the key advisor and support to the Minister. It retains centralised funding for a range of national services, including disability support and public health services.

In 2007:

- 3.38 million people visited a general practitioner at least once
- 1.7 million people visited a primary health nurse at least once
- 493 outbreaks of communicable diseases were investigated
- 47.6 million prescription items were dispensed
- 23 million laboratory tests were performed
- 699,955 hospital discharges for medical and surgical services occurred<sup>1</sup>
- 92,244 people accessed mental health services
- 437,584 cervical smears were taken
- 464,600 free influenza vaccinations were given
- 87,177 free annual checks for people with diabetes were undertaken
- 26,160 'green' prescriptions (advice on exercise or nutrition) were dispensed.

<sup>1</sup> This number can change as additional information is sent to the National Minimum Data Set (NMDS).

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



New Zealand's health and disability system has a mix of public and private ownership and funding that has developed in complexity over time.

The entire system stretches beyond the Ministry, DHBs, primary health organisations (PHOs), public health units (PHUs), private non-governmental providers, Māori and Pacific providers and independent general practitioners (GPs). It includes professional and regulatory bodies for all health professionals, including all medical and surgical specialist areas, nurses and allied health groups. There is a range of educational and research institutions that impact on demand and prioritisation of services as well as training of the workforce. There are also many consumer bodies and non-governmental organisations (NGOs) that provide services and advocate the interests of various groups, and more formal advocacy and inquiry boards, committees and entities.

All of these groups and individuals can have a significant influence over the priorities and demands on the system, and the linkages between them are not always clear. Good relationships between the various players in the system are essential for the effective operation of the system.

## **The statutory framework**

The New Zealand health and disability system's statutory framework is made up of over 20 pieces of legislation. The most significant are:

- New Zealand Public Health and Disability Act 2000 (the NZPHD Act)
- Health Act 1956<sup>2</sup>
- Crown Entities Act 2004.

### **New Zealand Public Health and Disability Act 2000 (the NZPHD Act)**

The NZPHD Act establishes the structure underlying public sector funding and the organisation of health and disability services. It establishes District Health Boards, and sets out the duties and roles of key participants, including the Minister of Health, Ministerial committees, and health sector provider organisations.

The NZPHD Act also sets the strategic direction and goals for health and disability services in New Zealand. These include to improve health and disability outcomes for all New Zealanders, to reduce disparities by improving the health of Māori and other population groups, to provide a community voice in personal health, public health, and disability support services and to facilitate access to, and the dissemination of information for, the delivery of health and disability services in New Zealand.

### **Health Act 1956**

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

<sup>2</sup> A new Public Health Bill has been drafted to replace the Health Act 1956, and it is awaiting consideration for reinstatement in the new Parliamentary term.

A new Public Health Bill was drafted to replace and modernise the 1956 Health Act. It would support New Zealand’s obligations under the International Health Regulations 2005,<sup>3</sup> and provide for communicable disease management in New Zealand, including updated systems for disease notification and contact tracing. The Public Health Bill, if passed as is, would continue the role of territorial authorities in environmental health to reflect provisions in the Local Government Act 2002 and a wider range of enforcement options. In its current form, it also introduces measures to address risk factors for non-communicable diseases such as heart disease, diabetes and cancer.

**The Crown Entities Act 2004**

Many of the organisations that provide health services are Crown Entities. This Act provides the fundamental statutory framework for the establishment, governance, and operation of Crown entities. It clarifies accountability relationships and reporting requirements between Crown entities, their board members, responsible Ministers, and the House of Representatives. Crown Entities are described in more detail from page 32.

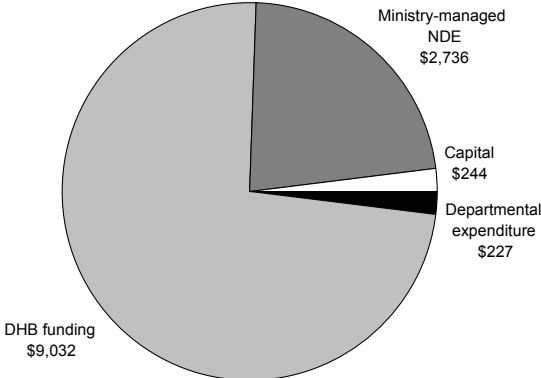
A more comprehensive summary of all health legislation is provided in Appendix 1.

**Funding overview**

Like most OECD countries, New Zealand’s health and disability system is predominately funded from general taxation. The Vote Health allocation for 2008/09 is \$12.240 billion. This is second only to Social Development with \$17.676 billion.

Most Vote Health funding is managed by DHBs, but 22% is non-departmental expenditure (NDE) service funding managed by the Ministry. There are also small allocations (of less than 2% each) for the Ministry’s operating expenses and for Capital expenditure.

**Figure 2:** Vote Health 2008 by appropriation type (\$12 billion)



Vote Health does not represent the total money spent on health services in New Zealand. The total health spend, as described in OECD comparison figures, also includes funding from other Government agencies and entities, from local government and from private insurance and out of pocket payments. For example, health administers ACC funding for public health acute services provided by DHBs for ACC clients.

Further details of the funding of the health and disability system are provided from page 37.

<sup>3</sup> The International Health Regulations provide a global regime to manage the international spread of disease and prevent or control international emergencies (such as avian influenza) and is discussed in more detail on page 46.



## The Minister of Health

The Minister of Health has the ultimate responsibility for all health policy decisions and all expenditure from Vote Health. The Minister's functions, duties, responsibilities and powers are provided for in the NZPHD Act and other legislation.

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

### Strategic oversight

Under the NZPHD Act the Minister of Health, in conjunction with the Minister for Disability Issues, is responsible for strategies that provide a framework for the system and for reporting on their implementation to Parliament.

Four key strategies currently in place are:

- the New Zealand Health Strategy
- the New Zealand Disability Strategy
- He Korowai Oranga: Māori Health Strategy
- the Primary Health Care Strategy.

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

The NZPHD Act also requires a strategy for nationally consistent standards and quality assurance programmes for health services and consumer safety. The *Improving Quality (IQ): A systems approach for the New Zealand health and disability sector* and the *IQ Action Plan: Supporting the improving quality approach* were developed to meet this requirement.

### Powers and responsibilities with respect to DHBs

The NZPHD Act and the Crown Entities Act 2004 set out accountability and reporting requirements between DHBs and other health Crown entities, their board members, their responsible Ministers on behalf of the Crown, and the House of Representatives.

The NZPHD Act provides the Minister with a number of powers and responsibilities with respect to DHBs. In particular, the Minister's consent and approval is required for DHBs' District Annual Plans, and the Minister reviews and comments on DHBs' and health Crown entities' Statements of Intent. The Minister is also responsible for reviewing DHBs' and other health Crown entities' performance against objectives agreed with the Government.

The Minister has reserve powers, generally intended for use in exceptional circumstances only. These are to:

- direct DHBs and health Crown entities to implement government policy
- require DHBs to provide or arrange for the provision of certain services

- appoint Crown monitors to sit on DHB boards
- dismiss DHB boards and replace them with Commissioners.

At a more general level, the Minister informs DHBs of the Government's expectations and requirements through the annual letter of expectations sent to DHBs along with the Annual Planning Package, usually in December each year. This is described under the DHB Performance and Accountability Arrangements section on page 40.

## **Ministerial appointments**

### **DHB boards**

Of the 11 members on each of the 21 DHB boards, seven are elected by the community every three years with the rest appointed by the Minister of Health. The Minister also appoints each chair and deputy chair from among the elected and appointed members. Current DHB chairs, deputy chairs and chief executive officers are listed on page 27.

The NZPHD Act requires the Minister to aim to ensure that Māori membership of each board is proportional to the number of Māori in the DHB's resident population, and that in any event there are at least two Māori members on each board.

Each board member serves for a maximum of three years initially, although appointed members can be appointed for shorter periods. An elected member can stand for re-election. Appointed members can also be reappointed but are not allowed to serve for more than nine consecutive years. Vacancies in either elected or appointed member positions can be filled by the Minister at any time.

### **Health Crown entity boards**

The Minister makes appointments to the following seven health Crown entity boards, (and may appoint a chair and deputy chair from among each board's members):

- the Alcohol Advisory Council of New Zealand (ALAC; eight members)
- the Crown Health Financing Agency (up to five members)
- the Health Sponsorship Council (between three and six members)
- the Health Research Council of New Zealand (10 members)
- the New Zealand Blood Service (up to seven members)
- the Mental Health Commission (three members)
- the Pharmaceutical Management Agency (Pharmac; up to six members).

As with DHB members, health Crown entity board members are typically appointed for terms of three years. Vacancies in board member positions can be filled by the Minister at any time. All members can be reappointed at the expiry of their terms.

The Health and Disability Commissioner is appointed by the Governor-General on the advice of the Minister of Health. This appointment is for a term of five years (or less).

More information about the Health Crown entities is set out later in this document (on pages 32–36).

## **Ministerial committees**

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

A full list of Ministerial committees and other statutory bodies can be found in Appendix 2.

## **Professional and regulatory bodies**

The Minister makes appointments to the 16 authorities under the Health Practitioners Competence Assurance Act 2003 (the HPCA Act) for the registration and oversight of practitioners in 21 health professions. The Minister is responsible for a single shared disciplinary body for all professions (the Health Practitioners Disciplinary Tribunal), and appoints the members of the Health Practitioners Disciplinary Tribunal panel (135 lay and professional members, one chair and three deputy chairs).

The role of the Health Practitioners Disciplinary Tribunal and appointments under the HPCA Act are described more fully under 'Ministerial Committees, Tribunals, Councils and Inspectors' in Appendix 2.

## **District inspectors**

The Minister appoints district inspectors under two separate pieces of legislation: the Mental Health (Compulsory Assessment and Treatment) Act 1992; and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. These inspectors assist people being assessed, treated, cared for or rehabilitated under these Acts by providing information and support to ensure their rights are upheld.

The functions of both types of district inspectors are described more fully in Appendix 2.

## **Statutory officers**

The principal 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 allows for central oversight of regulatory functions. The majority of these officers are employed in DHB-based public health units. The Director-General also appoints statutory officers under a range of other Acts, in particular the Smoke-free Environments Act 1990, the Tuberculosis Act 1948 and the Hazardous Substances and New Organisms Act 1996. City and district councils also appoint Environmental Health Officers under the Health Act, who assist councils to perform their environmental health functions under the Health Act.

Four Ministry staff, including the Director of Public Health, are currently designated by the Director-General as Medical Officers of Health for all health districts. In effect this ensures that there are four 'national' Medical Officers of Health who are able to exercise powers if required throughout New Zealand.

## **Health emergencies**

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

# The Ministry of Health

The Ministry of Health is the key agent of the Minister in the health and disability system. It provides a range of functions to support the Minister of Health and maintain the core of government's responsibilities for the health and participation of New Zealanders. The Ministry is policy advisor, regulator, and funder and provider of services. It provides leadership across the system to improve performance.

Although New Zealand has a devolved health and disability service model, the Ministry of Health continues to fund a broad range of national services (eg, public health, screening, well-child, disability support services) and provide shared support services, such as the processing of payments on behalf of the sector and the maintenance of health information.

The Ministry's goal is 'Healthy New Zealanders', and we aim to ensure that the health and disability support system works for all New Zealanders providing better health, reduced inequalities, better participation and independence, and trust and security.

Stephen McKernan is the Director-General of Health and Chief Executive of the Ministry of Health.



## Role of the Ministry

The Ministry's core functions are:

- strategy, policy and system performance – providing advice on improving health outcomes, reducing inequalities and increasing participation, nationwide planning, co-ordination and collaboration across the sectors
- servicing Ministers' offices and ministerial advisory committees
- monitoring and improving the performance of health sector Crown entities and District Health Boards, which are responsible for the health of their local communities
- funding and purchasing of health and disability support services on behalf of the Crown including maintenance of service agreements, particularly for public health, disability support services and other services that are retained centrally
- administration of legislation and regulations, and meeting legislative requirements
- information services
- payment services.

Ministry of Health Directorate Structure (as at 17 November 2008)

<p><b>Health and Disability Systems Strategy</b> Deputy Director-General Deborah Roche</p> <p>Business Unit</p> <p>Strategic Investment and Funding</p> <p>Strategic Workforce Development</p> <p>Policy Unit</p> <ul style="list-style-type: none"> <li>• Pacific Health</li> <li>• National Health Committee</li> <li>• ACART</li> <li>• NEAC</li> </ul> <p>Office of the Director of Public Health</p> <ul style="list-style-type: none"> <li>• Public Health Legislation Review</li> <li>• Global Health</li> <li>• Public Health</li> </ul> <p>Health and Disability Intelligence Unit</p> <p>Strategy Unit</p> <ul style="list-style-type: none"> <li>• Long-term System Framework</li> </ul>	<p><b>Māori Health</b> Deputy Director-General Teresa Wall</p> <p>Māori Health Policy</p> <p>Māori Health Relationships</p> <p>Strategic Projects</p>	<p><b>Population Health</b> Deputy Director-General Janice Wilson</p> <p>Deputy Director-General's Office</p> <p>Minimising Harm</p> <ul style="list-style-type: none"> <li>• National Drug Policy</li> <li>• Problem Gambling</li> <li>• Addiction Treatment Services</li> </ul> <p>Māori Population Health</p> <p>Health and Disability Services Policy</p> <ul style="list-style-type: none"> <li>• Primary Health Policy</li> <li>• Older People Policy</li> <li>• Child, Youth and Maternity Policy</li> <li>• Nutrition and Physical Activity Policy</li> <li>• Disability Policy</li> </ul> <p>Population Health Protection</p> <ul style="list-style-type: none"> <li>• Communicable Diseases</li> <li>• Immunisation</li> <li>• HPV</li> <li>• Environmental and Border Health</li> </ul> <p>Mental Health</p> <ul style="list-style-type: none"> <li>• Policy and Service Development</li> <li>• Mental Health Promotion</li> <li>• Office of the Director of Mental Health</li> <li>• Rights and Protection</li> </ul> <p>System Improvement</p> <ul style="list-style-type: none"> <li>• Ethics Committee</li> <li>• Mortality Committee</li> <li>• Committee Advisory</li> <li>• Infrastructure, Contracting and Workforce</li> </ul>	<p><b>Sector Capability and Innovation</b> Deputy Director-General Marge Apa</p> <p>Office of the Deputy Director-General</p> <p>Primary Health Care Implementation</p> <p>Clinical Services Development</p> <p>Oral Health</p> <p>Cancer</p> <p>Tobacco Policy and Implementation</p> <p>Māori Innovations</p> <p>Quality, Improvement and Innovation</p> <p>Healthy Eating – Healthy Action (HEHA)</p> <p>Long-term Conditions</p> <p>Nursing Team</p> <p>Pacific Innovations</p>	<p><b>Health and Disability National Services</b> Deputy Director-General Geraldine Woods</p> <p>Business Strategy</p> <p>Directorate Services</p> <p>Quality</p> <p>Clinical Training Agency</p> <p>Public Health</p> <ul style="list-style-type: none"> <li>• Northern Operations</li> <li>• Southern Operations</li> <li>• Personal Health Services</li> </ul> <p>Disability Support Services</p> <ul style="list-style-type: none"> <li>• Planning and Development</li> <li>• National Operations</li> </ul> <p>National Screening Unit</p> <ul style="list-style-type: none"> <li>• Antenatal and Newborn Screening</li> <li>• Cancer Screening</li> <li>• Communications and Marketing</li> <li>• Finance and Contracts</li> <li>• Quality Assurance</li> <li>• Strategy and Policy</li> <li>• Corporate Services</li> </ul>	<p><b>Sector Accountability and Funding</b> Deputy Director-General Anthony Hill</p> <p>Business Planning</p> <p>Funding</p> <ul style="list-style-type: none"> <li>• Elective Services</li> <li>• DHB Relations</li> <li>• Governance and Crown Entities</li> <li>• Industrial Relations</li> </ul> <p>Performance</p> <ul style="list-style-type: none"> <li>• Accountability</li> <li>• Monitoring</li> </ul> <p>Quality and Safety</p> <ul style="list-style-type: none"> <li>• HealthCERT</li> <li>• Medicines Control</li> </ul> <p>National Radiation Laboratory</p> <p>Finance</p> <ul style="list-style-type: none"> <li>• Financial Monitoring</li> </ul> <p>Service Analysis</p> <p>Audit and Compliance</p> <ul style="list-style-type: none"> <li>• Investigations</li> <li>• Risk Assessment</li> <li>• Audit</li> </ul> <p>Medsafe</p> <ul style="list-style-type: none"> <li>• Clinical Risk Management</li> <li>• Compliance Management</li> <li>• Legislation Review</li> <li>• Product Regulation</li> </ul>	<p><b>Information</b> Deputy Director-General Alan Hesketh</p> <p>Information Strategy and Architecture</p> <p>Programme Management Office</p> <p>Solutions Delivery</p> <p>Technology Services</p> <p>Sector Services</p> <p>Corporate Knowledge Services</p> <p>Directorate Services</p> <p>Relationship Management</p>	<p><b>Corporate Services</b> Deputy Director-General and Deputy Chief Executive Andrew Bridgman</p> <p>Business Manager</p> <p>Communications</p> <ul style="list-style-type: none"> <li>• Media</li> <li>• Web and Publications</li> </ul> <p>Human Resources</p> <ul style="list-style-type: none"> <li>• HR Services</li> <li>• HR Capability</li> </ul> <p>Capital and Planning</p> <ul style="list-style-type: none"> <li>• Planning and Funding</li> <li>• Facilities Management</li> <li>• Finance</li> <li>• Contract Support</li> </ul> <p>Government Relations and Director-General Support</p> <ul style="list-style-type: none"> <li>• Ministerial Services</li> </ul> <p>Health Legal Chief Legal Advisor</p>
<p><b>Risk and Assurance</b> Chief Internal Auditor Steve Brazier</p>							



## Executive Leadership Team

The Executive Leadership Team (ELT) focuses on strategic management, corporate governance, and organisation performance of the Ministry of Health. Specifically, the ELT supports the Director-General 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's objectives. This includes the people, information, structures, relationships, resources, culture, leadership, and systems to fulfil the Government's directions in the medium and long term
- supporting the Director-General's financial and operational delegations by providing advice on key matters of health and disability public policy and implementation.

The ELT meets twice monthly, on the 2nd and 4th Tuesday of the month. ELT members meet weekly with the Minister of Health and can have individual working relationships with Associate Ministers, depending on their specific portfolios. The ELT (collectively and individually) directly influences and models the desired organisational culture.

The ELT membership is decided by the Director General and comprises:

- Stephen McKernan, Director-General of Health
- Andrew Bridgman, Deputy Director-General (DD-G) Corporate Services and Deputy Chief Executive
- Deborah Roche, DD-G Health and Disability Systems Strategy
- Teresa Wall, DD-G Māori Health
- Janice Wilson, DD-G Population Health
- Margie Apa, DD-G Sector Capability and Innovation
- Geraldine Woods, DD-G Health and Disability National Services
- Anthony Hill, DD-G Sector Accountability and Funding
- Alan Hesketh, DD-G Information
- Dr David Galler, Principal Medical Advisor

Steve Brazier is the Chief Internal Auditor, leading Risk and Assurance, and reports independently to the Director-General but is not a member of ELT.

## Chief Advisors

The Ministry has health professional and advisory roles that provide clinical and technical advice to the Minister and the Ministry of Health. Some roles also have clinical decision making responsibilities and/or statutory functions. Most are based in the Sector Capability and Innovation Directorate. The Chief Advisors are:

- **Dr Api Talemaitoga, Chief Advisor, Pacific Health**, is a practising general practitioner. Api provides advice on the impact of the health and disability system on Pacific populations and supports relationships in the wider Pacific region
- **Dr Ashley Bloomfield, National Director, Tobacco Control Programme and Chief Advisor, Public Health**, provides technical oversight of the tobacco control programme and public health specialist advice on other public health issues, including screening programmes and other non-communicable disease issues
- **Dr David Chaplow, Director of Mental Health**, a statutory role, responsible for the administration of the Mental Health Act under the direction of the Minister and Director-General. Dr Chaplow is a clinical reader at Auckland University and the elected Chair of the Forensic section of the Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- **Dr David St George, Chief Advisor, Integrative Care**, provides professional leadership, direction and advice on complementary and alternative medicines (CAM), and on their integration with conventional healthcare, particularly primary care and long term conditions. Dr St George studied medicine at Auckland Medical School, and epidemiology at McGill University in Montreal, Canada
- **Gillian Grew, Chief Advisor, Services** leads the design of the quality and safety regulatory regime for health and disability service sector focused initially on hospitals and residential services
- **Dr Greg Simmons, Chief Advisor, Population Health** provides professional leadership to strengthen system networks and assist in implementing policy initiatives which promote and protect population health
- **Dr Jim Primrose, Chief Advisor, Primary Health Care** provides advice on the strategic and implementation implications of primary health care. Dr Primrose's career spans general practice and primary health management
- **Dr John Childs, National Clinical Director, Cancer Control**, provides clinical oversight and decision making for the National Cancer Programme. Dr Childs is also a practicing radiation oncologist at Auckland DHB
- **Lester Mundell, Chief Advisor, Disability Support Services and Director of Intellectual Disability Compulsory Care and Rehabilitation (IDCC&R)**, provides strategic advice on disability support services in liaison with the disability sector. He also manages individual cases and has statutory functions under the IDCC&R Act 2003. Mr Mundell has a background in social work, community services funding and social services policy
- **Dr Mark Jacobs, Director of Public Health** – a statutory role, providing independent advice to the Director-General and Minister on public health. Dr Jacobs is a specialist public health physician, with broad experience as a public health practitioner and manager in Australia and the Pacific
- **Mark Jones, the Chief Nurse**, provides advice on effective nursing and nursing workforce developments. Mark has a background in primary care and public health
- **Dr Pat Tuohy, Chief Advisor, Child and Youth Health**, provides advice on child and youth health and wellbeing, and opportunities for improvement. Dr Tuohy is a specialist paediatrician with a particular interest in community child health
- **Dr Robin Whyman, Chief Dentist**, provides clinical oversight of oral health and dentistry in New Zealand. Robin also practices part time at Hutt Valley District Health Board



- **Dr Sandy Dawson, Chief Clinical Advisor**, provides clinical advice with particular emphasis on long term conditions such as diabetes and cardiovascular disease
- **Wi Keelan, Chief Advisor, Māori Health** has a background in psychiatric nursing and provides advice on the impact of the health and disability system on Māori.

## Organisational structure of the Ministry

The Ministry is organised into the following directorates to reflect a ‘whole of system’ focus on health and disability support services, that includes policy development, implementation and monitoring, and engagement with the broader system at all levels. It is designed to ensure the Ministry can lead improved system performance, and ultimately improve value and health outcomes for individuals, communities, patients and the New Zealand taxpayer.

The directorates are designed to ensure linkages support a flow of information and work across the Ministry. Strategic policy development occurs in the Health and Disability Systems Strategy and Māori Health directorates and flows into operational policy development in Population Health directorate and the implementation of policy by the Sector Capability and Innovation and National Health and Disability Services directorates.

System performance is monitored and managed by Sector Accountability and Funding directorate aided by information from the Information directorate. This information is then fed back into the policy and implementation directorates.

Corporate Services maintains the ownership interests of the Ministry of Health, ensuring the capability exists to support the Ministry’s roles and functions. Corporate Services provides ‘wrap around’ services to enable directorates to manage their business.

A more detailed description of each directorate follows.

**Figure 3:** Whole of system view of the Ministry of Health



## The Directorates

### Health and Disability Systems Strategy Directorate (HDSS)

Deborah Roche, Deputy Director-General



The Health and Disability Systems Strategy Directorate (HDSS) provides strategic and whole-of-system perspectives and advice on the development of the health and disability system to achieve better health and participation, and to reduce inequalities.

The seven units in HDSS each have their own clear purpose and functions. They work together and across directorates to:

- provide advice and develop policy on strategic issues relating to investment in, and the performance of, New Zealand's health and disability system
- provide strategic and whole of system advice and challenge on key priorities and issues including prioritisation and development of the Long Term System Framework
- develop advice on strategies that influence demand and increase supply of New Zealand's health and disability workforce
- undertake strategic policy development for key systems functions and population groups including Māori, and Pacific peoples
- ensure New Zealand meets its national and international statutory public health obligations and protects and promotes the health of the population through effective public health action
- obtain and provide evidence for the strategic development of New Zealand's health and disability system
- provide secretariat support for the National Health Committee (NHC), National Ethics Advisory Committee (NEAC) and the Advisory Committee on Assisted Reproductive Technology (ACART)
- build an effective and efficient directorate through robust business management practices.

### Māori Health Directorate (MHD)

Teresa Wall, Deputy Director-General



The Māori Health Directorate is the primary advisor on Māori health and reducing Māori inequalities. It advises on:

- implementing section 4 of the NZPHD Act (to recognise and respect the principles of the Treaty of Waitangi) in the health and disability system
- responding to Waitangi Tribunal claims in collaboration with the Sector Accountability and Funding Directorate
- implementing He Korowai Oranga and Whakatātaka Tuarua

- monitoring the development and implementation of Māori health action plans in DHBs with the Sector Accountability and Funding Directorate
- supporting the Ministry and sector implementation of other health and disability strategies for Māori in conjunction with the Population Health and Sector Capability and Innovation Directorates
- developing policy settings to support Māori participation in the sector at all levels
- leading, in conjunction with HDSS, the reducing inequalities work programme across the Ministry.

The Directorate has a new function to monitor the Ministry on how it improves Māori health and reduces Māori health inequalities. This includes:

- ensuring Directorates self-evaluate their activities on how they work to improve Māori health and reduce Māori health inequalities; and then monitoring the self-evaluations
- placing a strong emphasis on raising awareness in the sector. A number of analytical tools including the Health Equality Assessment Tool and the Whānau Ora Health Impact Assessment have been developed to guide policy makers and others and ensure improving Māori health and reducing inequalities is appropriately considered
- maintaining a focus and impetus on improving Māori health and reducing health inequalities for Māori.

### **Population Health Directorate (PHD)**

Janice Wilson, Deputy Director-General

The Population Health Directorate (PHD) identifies population health needs, develops policies and programmes that respond to those needs, and organises the implementation of specified services through DHBs (and in some cases through the Ministry). Its overall goal is to maintain and improve the health status of the whole population, increase participation and independence and reduce inequalities between population groups. Advice is also given on eligibility and access to services.



PHD spans the life course of the population, from ante-natal care and birth, through childhood, youth development and care for older people, to ensure that health and disability services respond to the needs of the population at each stage along the continuum.

Specifically identified population groups within the wider New Zealand population, who experience differing health outcomes, are a key focus. These include rural populations, men/women, Maori, Pacific and other ethnic groups, and populations with specific health and disability needs (eg, people with addiction/mental health issues, people with disabilities etc). Maori, Pacific and other population groups are supported to improve their access to services and to experience health and disability outcomes commensurate with the general population.

The Directorate has 6 Groups:

- Health and Disability Services Policy: provides policy advice on primary health care, children, young people and maternity services, older people; people with disabilities and chronic disease prevention issues (eg: nutrition and physical activity).
- Population Health Protection: covers environmental health, communicable disease and immunization.
- Mental Health: includes the Office of the Director of Mental Health, mental health legislation and regulation, policy and service development and mental health promotion.
- Minimizing Harm: covers national drug policy, addiction treatment policy, problem gambling and effective interventions in the criminal justice sector.
- Maori Population Health: covers forensic mental health, Maori mental health and work to improve Maori health outcomes and reduce inequalities for Maori across the whole Directorate.
- System Improvement: supports regional and multi regional ethics committees and mortality committees, provides policy advice on quality and safety and service specific workforce development and develops information and accountability frameworks for specific service developments across the Directorate.

PHD has a particular focus on investment at the 'front end' of the health system and on system improvement through a range of strategies.

Policy and funding interventions are crafted around a well developed base of information and evidence. Leadership and influence is exercised across the Ministry of Health, government and the wider health sector. The Ministry aims to be influential in bringing all those factors together and supporting people to participate fully in their communities, as health interventions are not the only factors that contribute to health status.

PHD promotes public interest and confidence in policies and programmes that maintain and improve health and independence, through:

- public education, information and consultation,
- monitoring and reporting on trends in morbidity and mortality;
- ensuring there are mechanisms to protect those who are vulnerable within the health system, for example, through the Office of the Director of Mental Health
- systems of ethical review,
- overseeing health service safety standards, and
- oversight of legislation e.g. the Mental Health Act.

## **Sector Capability and Innovation Directorate (SCI)**

Margie Apa, Deputy Director-General



The Sector Capability and Innovation Directorate (SCI) works proactively with the sector to support implementation, build capability and share innovations that operationalise the Minister's strategic priorities. The Directorate includes the following current priority and capability programmes:

### **Priority programmes:**

- Primary Health Care Implementation: works with DHBs and the Primary Health Care Advisory Council to support improvements in primary health care.
- Healthy Eating – Healthy Action: works through cross sector relationships to review and implement the Healthy Eating – Healthy Action Plan.
- Clinical Service Development: provides advice and supports clinical service improvements in the treatment and management of many long term conditions including diabetes, cardiovascular disease and hepatitis C.
- Oral Health: implements the Oral Health Action Plan and providing service development and implementation support for oral health services.
- Cancer Control: implements the Cancer Control Action Plan including supporting the Cancer Control Steering Group and service development and implementation support for the Cancer Control programme.
- Tobacco Policy: implements the 'Clearing the Smoke' Tobacco Control Action Plan and provides policy advice, service development and implementation support for the Tobacco control programme.

### **Capability programmes:**

- Māori Innovations: administers the Māori Provider and Workforce Development Funds to ensure Māori providers and workforce are sustainable.
- Pacific Innovations: administers the Pacific Provider and Workforce Development Funds to ensure Pacific providers and workforce are sustainable.
- Nursing Innovations: supports the development of nursing professionals and works to improve the use of the nursing workforce.
- Long Term Conditions Framework: implements the National Health Committee recommendations to develop an operational framework for the co-ordination of, and a nationally consistent approach to, the management of long-term conditions.
- Quality, Improvement and Innovation: implements the national quality and service improvement programmes including the Health Innovations programme.

SCI's core business is to support the sector's implementation of the Government's health and disability strategies and key priorities to see measurable improvements in national Health Target areas. This may be achieved through shared best practice, the generation, diffusion and spread of proven innovations, improvement experience and/or learning that reflects the Government's priorities for health improvement.

## Health and Disability National Services Directorate (HDNS)

Geraldine Woods, Deputy Director-General

The Health and Disability National Services Directorate (HDNS) plans for and buys the health and disability support services that Government has determined shall be purchased nationally. There are approximately \$2.3 billion of these services bought by the Ministry of Health annually; \$1.5 billion of these are the responsibility of the HDNS.



They are:

- **Disability Support Services:** purchased for people with a long-term physical, intellectual and/or sensory impairment requiring ongoing support who are (generally) under the age of 65. They aim to ensure disabled people are valued, included, and respected, have influence and control, are connected to communities and have useful disability support services.
- **Personal and Public Health Services:** nationally purchased to promote health, prevent illness, reduce inequalities, ensure cohesion between national and regional services, and contribute to DHB outcomes. These services include immunisation, family violence prevention, mental health promotion, nutrition, physical activity, sexual health promotion, tobacco control, public health unit services, emergency ambulance services, maternity services, well-child services, and HealthLine.
- **Population Screening:** The National Screening Unit (NSU) was established in 2001 to provide screening programmes in New Zealand. The NSU is responsible for the safety, effectiveness and quality of organised screening programmes. The NSU currently co-ordinates five national screening programmes: BreastScreen Aotearoa, National Cervical Screening Programme, Newborn Metabolic Screening Programme, Antenatal HIV Screening and Newborn Hearing Screening and antenatal screening for Down syndrome. The NSU monitors the quality of screening programmes, and works with expert groups to make sure each screening programme is based on the latest evidence and meets high standards. The NSU also advises the Government on other potential programmes.
- **Workforce Development:** The Clinical Training Agency (CTA) purchases post-entry clinical training. This training is clinical, vocational, nationally recognised, a minimum of six months long, and occurs after entry into a health profession. The CTA also conducts workforce analysis and development, including joint projects with other directorates and work with sector reference groups. The CTA is also responsible for the overseas trained doctors programme.
- **Developing and Disseminating Information:** supports the health and disability support services in improving health and independence by enabling better planning, policy, and performance management.



## **Sector Accountability and Funding Directorate (SAF)**

Anthony Hill, Deputy Director-General



The Sector Accountability and Funding Directorate (SAF) is responsible for funding, monitoring and ensuring the sector is compliant with accountability expectations. It ensures compliance with some health regulations. It advises on the current performance of the sector, areas where targeted effort may be required, and trends in performance indicators and service expectations by:

- managing the distribution of funding to Crown-owned entities (eg, DHBs) and the accountability arrangements for the use of public resources, and advising on the funding arrangements (eg, inter-district flows, maintenance of service frameworks, national pricing)
- developing and implementing the funding mechanisms and the accountability framework (eg, district annual planning, reporting and monitoring processes) across the whole system, including public health, mental health and primary health implementation to achieve better health and reduced inequalities
- actively monitoring and advising on the financial and non-financial performance of health Crown entities and the Ministry's role as direct funder of health and disability services, providing strategic advice on trends in performance against target indicators, and identifying opportunities for improvement and service reviews
- working with the sector to implement government policy on elective services
- managing relationships with Crown entities, including Board appointments, support for good corporate governance practice (including induction) and co-ordination of DHB elections
- managing the assessment of sector capital business cases against agreed capital business planning frameworks
- providing advice on industrial relations across the sector
- providing service analysis, benchmarking, best practice research, and administering the national pricing programme
- providing an account manager function for health Crown entities to support high-level relationship management, ownership, purchase monitoring and entity co-operation at regional and national levels
- administering the Ministry's regulatory powers to coerce and/or enforce statutory compliance, including audit, certification processes, consolidating and building the capability and capacity to investigate, examine risks and oversee the consequences of failure or breach of those requirements.

### **Audit and Compliance**

Audit, investigation, data risk analysis, and prosecution capability, are conducted for all non-clinical fraud and inappropriate claiming of government payments and subsidies by health service providers. These include pharmacists, PHOs, laboratories, midwives, dentists, residential homes, mental health, carer support, etc. Services are provided on a national and ad hoc basis to all DHBs and Ministry of Health directorates. The unit operates from Auckland, Wanganui, Wellington and Christchurch.

Michael Moore is the National Audit Manager.

### **Quality and Safety**

Quality and Safety administers three primary pieces of legislation, from its offices in Auckland and Wellington. The Health and Disability Services (Safety) Act 2001 provides for the certification of approval to operate public and private hospitals and rest homes against regulatory and sector standards, and co-ordinates the services of Designated Audit Agencies. The Misuse of Drugs Act 1975 and the Misuse of Drugs Regulations 1977 provide for licensing and standards, authorise import and export licences for controlled drugs, pharmacy wholesale, retail and hawkers and to deal, possess, cultivate and grow industrial hemp. Quality and Safety also monitors aberrant prescribing.

Rose Wall is the Manager of Quality and Safety.

### **Medsafe**

The New Zealand Medicines and Medical Devices Safety Authority (Medsafe) administers the Medicines Act 1981 and Medicines Regulations 1984. This involves regulating therapeutic products in New Zealand. Therapeutic products include medicines and related products, herbal remedies, and controlled drugs used as medicines. Medsafe enforces product safety through pre-marketing approval for new and changed medicines. It also monitors the safety of medicines and medical devices in use. It has bases in both Wellington and Auckland.

The New Zealand and Australian governments previously agreed to establish a joint trans-Tasman therapeutic products regulatory scheme to regulate medicines, medical devices, and complementary medicines across both countries. It would replace the Therapeutic Goods Administration in Australia and Medsafe in New Zealand. The legislation to establish the joint scheme was introduced into Parliament in December 2006 and referred to the Government Administration Committee. However, it was postponed in July 2007 because it did not have sufficient parliamentary support to progress further.

Dr Stewart Jessamine is the Manager of Medsafe.

### **National Radiation Laboratory**

The National Radiation Laboratory (NRL) is based in Christchurch. It provides expert advice, services and research about public, occupational and medical exposure to radiation, the performance of radiation equipment, and the measurement of radiation and radioactivity.

The NRL's functions are provided for in the Radiation Protection Act 1965 and the Radiation Protection Regulations 1982. The Minister of Health and the Director-General of Health are formally responsible for the administration of the Act.

The Radiation Protection Act restricts radioactive materials and irradiating apparatus to people holding a licence. Applications for some classes of licence for medical purposes must be referred to the Medical Licensing Advisory Committee. The Act also sets up an



advisory body called the Radiation Protection Advisory Council to advise the Minister and the Director-General about licensing decisions and matters of policy.

Jim Turnbull is Group Manager of the National Radiation Laboratory.

### **Information Directorate**

Alan Hesketh, Deputy Director-General

The Information Directorate provides leadership to improve collaboration and co-operation across the sector's information systems. It also develops, maintains, and ensures access to all the key information databases held by the Ministry, and makes and monitors payments to health providers.



The Information Directorate works with HDSS Directorate, to provide strategic advice to the Director-General and the ELT on the medium to long-term information needs and infrastructure of the system to meet future health service and population health needs.

A service-level agreement will be established to define the information support needs required for the Ministry of Health as distinct from sector information requirements. This will enable the Information directorate to manage all IT infrastructures for the Ministry.

The Information Directorate implements the National Systems Development Programme (NSDP), which aims to consolidate, rationalise and optimise core payment, information and connectivity systems, including:

- health payment systems, including capitation funding systems
- health information and analysis systems
- patient identity data systems
- mechanisms through which external parties access the above systems.

The Directorate also services the Health Information Strategy Advisory Committee (HISAC) and works with HISAC to implement the 12 Action Zones of the Health Information Strategy for New Zealand.

### **Corporate Services Directorate (CSD)**

Andrew Bridgman, Deputy Director-General and Deputy Chief Executive

The Corporate Services Directorate ensures that the other Ministry of Health directorates have the resources and corporate systems and processes to control and expedite the management of their businesses. The following six groups provide a range of services to support Ministry line managers:



- Capital and Planning: oversees and co-ordinates Ministry business planning and delivers accountability documents. Ensures the Ministry is financially sustainable, including Vote management.

- Health Legal: provides legal advice to the Minister and the Ministry. Gives advice to ensure the Ministry is complying with its statutory and regulatory functions. Provides support and advice on Ministry contracting and the drafting of legislation.
- Communications: manages the internal and external communication needs of the organisation, including web, publications and the management of media relations.
- Government Relations: provides Ministerial support services, including staff for Ministers' offices, draft replies to correspondence, briefing requests, and parliamentary questions. Manages the Ministry's response to requests under the Official Information Act, and requests from Select Committees. Advises the Ministry about government and public service processes.
- Human Resources: provides human resources services and organisational development support.
- Director-General Support: co-ordinates the business of the Director-General by identifying and responding to potential emerging issues, providing peer review and oversight of key Ministry documents and providing other general or project support for the Director-General as required.

## **Risk and Assurance**

The Risk and Assurance Group has two core responsibilities: assurance services and the co-ordination of emergency preparedness in the Ministry and the health sector. It provides independent advice to the Director-General on strategic and operational risks in the Ministry and on the effectiveness of internal control systems. It also leads health emergency management, including pandemic planning, across the health system and across Government.

There is also an Audit and Finance Risk Assurance Committee which independently monitors the performance of the Ministry of Health.

Steve Brazier is the Chief Internal Auditor and National Co-ordinator – Emergency Planning.

## **Statutory positions in the Ministry**

### **Director-General of Health**

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

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

Stephen McKernan is the Director-General of Health.

### **Director of Mental Health**

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

Dr David Chaplow is the Director of Mental Health.

Dr Charles Hornabrook is the Deputy Director of Mental Health.

### **Director of Public Health**

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

Dr Mark Jacobs is the Director of Public Health.

### **Chief Financial Officer**

The Public Finance Act 1989 requires all departments to have a chief financial officer responsible for signing departments' statements of intent and annual accounts. The chief financial officer ensures that internal controls are effective, and efficient.

Andrew Gavriel is the Chief Financial Officer.

## District Health Boards

District Health Boards (DHBs) provide or fund a specified range of health and disability services for a specified population in each district. The 21 DHBs have existed since 1 January 2001 when the New Zealand Public Health and Disability (NZPHD) Act 2000 came into force.

### Objectives of DHBs

Under the NZPHD Act, DHBs must:

- improve, promote and protect the health of communities
- promote the integration of health services, especially primary and secondary services
- promote effective care or support of those in need of personal health services or disability support
- promote independence, inclusion and participation in society for people with disabilities
- reduce health outcome disparities between various population groups.

DHB populations and expenditure			DHB boundaries
DHB	Population (000s) approximate	Annual funding (\$ million)	
Waitemata	516	\$998	
Canterbury	491	\$1,103	
Counties Manukau	468	\$916	
Waikato	355	\$770	
Auckland	439	\$873	
Capital & Coast	282	\$531	
Bay of Plenty	204	\$485	
Otago	185	\$415	
MidCentral	165	\$368	
Northland	154	\$383	
Hawke's Bay	153	\$355	
Hutt	141	\$283	
Nelson Marlborough	135	\$307	
Southland	110	\$232	
Taranaki	107	\$253	
Lakes	102	\$229	
Whanganui	63	\$170	
South Canterbury	55	\$137	
Tairāwhiti	45	\$113	
Wairarapa	39	\$99	
West Coast	32	\$101	

Source: Statistics NZ population projections, September 2007.

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

## **DHB governance**

DHBs are governed by boards comprising up to 11 members: seven are elected by the public every three years, and up to four additional members can be appointed by the Minister of Health.

DHB elections are held concurrently with local government elections. DHB appointments are largely made in the weeks following the election and terms of office are timed to coincide with those of elected members. The last DHB elections were held in October 2007 and the next will be held in October 2010.

DHB boards are required to have three statutory advisory committees: a hospital advisory committee, a community and public health advisory committee, and a disability support advisory committee. Boards may also set up additional committees to suit their needs, such as audit and risk committees, and Māori or Iwi relationship bodies. Committee members can be either board members or members of the public.

## **DHBs and Māori**

The role of DHBs in the NZPHD Act identifies the need to recognise and respect the principles of the Treaty of Waitangi and to enable Māori to contribute to decision-making on, and to participate in, the delivery of health and disability support services.

### **Māori participation in decision-making**

The Minister of Health has the responsibility, under the NZPHD Act, to 'endeavour to ensure' there are at least two Māori board members on each DHB. Many DHBs also have formal arrangements with Iwi or local Māori groups for example, through a Māori relationship board. The Māori relationship board model assists DHBs to develop effective Māori health strategies by enabling local Iwi/Māori to influence the planning, purchasing, delivery and monitoring of health services for Māori in their region. Māori relationship boards provide independent advice to DHBs and typically comprise representatives from local Iwi and hapū (manawhenua and/or matawaka), Māori groups such as runanga, and individual Māori with an interest or involvement in health issues.

### **Māori involvement in service delivery**

DHBs also have a role in fostering Māori involvement in service delivery. The main way this is interpreted is through building a stronger Māori health and disability workforce and by supporting Māori health and disability providers in their districts.

### **Improving Māori health outcomes**

One of the objectives of DHBs – as set out in the NZPHD Act – is to reduce disparities by improving health outcomes for Māori and other population groups. This starts with good planning and DHBs are required to undertake health needs assessments to understand the health needs (and inequalities) in their communities and to plan services, through district strategic plans, around these needs.

The New Zealand Health Strategy states that the principle of acknowledging the special relationship between Māori and the Crown should be reflected across the health sector. DHBs must ensure their district strategic plans reflect the overall direction established in the New Zealand Health Strategy and the New Zealand Disability Strategy.

DHBs also have a role in implementing He Korowai Oranga (the Māori health strategy), which provides a framework for action to improve Māori health and reduce inequalities. DHBs also have specific responsibilities for actions in Whakatātaka Tuarua, the second Māori Health Action Plan.

## DHB Office Holders and Chief Executives<sup>4</sup>

DHB	Chair (elected or appointed)	Deputy chair (elected or appointed)	Chief Executive Officer
Northland	Lynette Stewart (appointed)	Bill Sanderson (elected)	Karen Roach
Waitemata	Kay McKelvie (appointed)	Max Abbott (elected)	Dave Davies
Auckland	Pat Snedden (appointed)	Harry Burkhardt (appointed)	Garry Smith
Counties Manukau	Gregor Coster (appointed)	Paul Cressey (elected)	Geraint Martin
Waikato	Jerry Rickman (appointed)	Sally Christie (elected)	Craig Climo
Lakes	Stewart Edward (appointed)	Lyall Thurston (elected)	Cathy Cooney
Bay of Plenty	Mary Hackett (elected)	Graeme Horsley (appointed)	Phil Cammish
Tairāwhiti	Ingrid Collins (elected)	Pene Brown (appointed)	Jim Green
Taranaki	John Young (appointed)	Peter Catt (elected)	Tony Foulkes
Hawke's Bay	Sir John Anderson (Commissioner)	Ian Brown, Brian Roche, Ngahiwi Tomoana (Deputy Commissioners)	Chris Clarke
Whanganui	Kate Joblin (appointed)	Ormond Stock (appointed)	Julie Patterson
MidCentral	Ian Wilson (appointed)	Ann Chapman (elected)	Murray Georgel
Hutt Valley	Peter Glensor (elected)	Sharron Cole (appointed)	Chai Chuah
Capital and Coast	Sir John Anderson (appointed)	Ken Douglas (appointed)	Ken Whelan
Wairarapa	Bob Francis (appointed)	Janine Vollebregt (elected)	David Meates (until February 2009)
Nelson Marlborough	Suzanne Win (appointed)	Liz Richards (elected)	John Peters

<sup>4</sup> As at 1 October 2008

<b>DHB</b>	<b>Chair (elected or appointed)</b>	<b>Deputy chair (elected or appointed)</b>	<b>Chief Executive Officer</b>
West Coast	Rex Williams (appointed)	Christine Robertson (appointed)	Joel George (interim)
Canterbury	Alistar James (appointed)	Olive Webb (elected)	Mary Gordon (Acting until February 2009)
South Canterbury	Joe Butterfield (appointed)	Ron Luxton (elected)	Chris Fleming
Otago	Richard Thomson (elected)	Susie Johnstone (appointed; joint Otago/Southland deputy chair)	Brian Rousseau
Southland	Dennis Cairns (appointed)	Susie Johnstone (appointed; joint Otago/Southland deputy chair)	Brian Rousseau

## Primary Health Organisations (PHOs)

Primary health organisations (PHOs) are funded by DHBs to provide a set of essential primary health care services to those people who are enrolled with the PHO. In particular, these comprise General Practice (GP) services.

Each PHO has a contract with its DHB to provide these services, called the Primary Health Organisation Agreement. The DHB is responsible for monitoring whether its PHOs are delivering services according to the agreement.

PHOs can take a variety of legal forms, such as non-profit companies, incorporated societies or trusts. PHOs are required to involve their communities in their governance processes, and must show they are responsive to communities' priorities and needs.

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

Although primary health care practitioners, such as General Practitioners (GPs) and allied health professionals, are encouraged to join PHOs, membership is voluntary. As at 1 July 2005, 3.85 million New Zealanders were enrolled with one of the 79 PHOs nationwide.

A PHO Taskforce, comprising members from PHOs, meets every six weeks and gives advice to the Ministry from the PHO perspective. A community council is being established to provide the Ministry with advice on the Primary Health Care Strategy from a consumer/community perspective.



## Public Health Units (PHUs)

Regional public health services are delivered by 12 DHB-owned public health units (PHUs) and various non-governmental organisations (NGOs). DHB-based services and NGOs each deliver approximately half of such services.

Public health units focus on 'core public health services', as specified in the *Public Health Services Handbook*, including environmental health, communicable disease control, tobacco control and health promotion programmes. Many of these services include a regulatory component performed by statutory officers appointed under a various statutes, though principally under the Health Act 1956. These statutory officers are employed by DHBs but are personally accountable to, and subject to, direction from the Director-General of Health. Statutory officers and public health units also work with the Ministry's Health and Disability Systems Strategy Directorate (Office of the Director of Public Health), Population Health Directorate and Health and Disability National Services Directorate, around ongoing technical, legislative and policy support, funding and co-ordination of services.

The Regional Public Health Units are:

- Northland Primary and community health services
- Auckland Regional Public Health Services
- Waikato Public Health Unit
- Toi Te Ora Public Health Unit (with offices in Tauranga, Whakatane and Rotorua covering Bay of Plenty and Lakes DHBs)
- Tairāwhiti Public Health Unit
- Hawkes Bay Public Health Unit
- Taranaki Public Health Unit
- Mid Central Public Health Unit (covering both Mid Central and Whanganui DHBs)
- Hutt Valley Regional Public Health (covering Wellington, Wairarapa and the Hutt Valley DHBs)
- Nelson Public Health Unit (based in Nelson Marlborough DHB)
- Christchurch community and public health (covering the West Coast, Canterbury and South Canterbury DHBs)
- Public Health South (covering Otago and Southland DHBs)

## Non-governmental Organisations (NGOs)

Health and Disability NGOs include a wide range of organisations working in the health and disability system. They receive significant funding (in the order of \$2–\$4 billion per year) from both the Ministry and DHBs. Many are non-profit organisations and along with providing services to consumers they are a valuable contact with community level organisations.

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

The NGO Working Group is made up of 13 elected representatives from the NGO sector and two (non-voting) Ministry of Health members. It is funded through a contract with the Ministry, and aims to build a strong, respectful, innovative and proactive relationship between the Ministry and NGOs, including Māori and Pacific NGOs.

The Ministry's NGO Relationship Manager implements the formal relationship between the Ministry and the NGOs, and maintains communication between the Ministry and the NGO sector. The NGO Relationship Manager also works with other agencies such as the Ministry of Social Development on government-community relationships.

Forums are held twice a year between the Ministry and the health and disability NGO sector. The forums are an opportunity to discuss key issues and to share these with the Ministry and other stakeholders. They are also the opportunity for the NGO sector to set an agenda of work for the Working Group to progress between meetings on behalf of the forum.

## Crown Entities and Agents

In addition to DHBs, the Crown Entities Act 2004 lists a number of other health Crown entities. These are also responsible to the Minister of Health. The Crown Entities Act establishes three different types of Crown Entity, as described below.

### Health Crown entity office holders and chief executive officers<sup>5</sup>

Entity	Chair/ Office holder	Deputy chair/ Office holder	Chief Executive Officer
<b>Crown agents</b>			
Crown Health Financing Agency	John Anderson	[no current deputy]	Graeme Bell
Health Research Council of New Zealand	Graeme Fraser	John Hay	Robin Olds
Health Sponsorship Council	Hayden Wano	[no current deputy]	Iain Potter
New Zealand Blood Service	Anne Urlwin	[no current deputy]	Fiona Ritsma
Pharmaceutical Management Agency (Pharmac)	Richard Waddell	Gregor Coster	Matthew Brougham
<b>Autonomous Crown entities</b>			
Alcohol Advisory Council of New Zealand (ALAC)	Peter Glensor	Trevor Shailer	Gerard Vaughan
Mental Health Commission	Peter McGeorge (Chair, Commissioner)	Bice Awan (Commissioner) Ray Watson (Commissioner)	Selwyn Katene (General Manager)
<b>Independent Crown entities</b>			
Health and Disability Commissioner	Ron Paterson (Commissioner)	Rae Lamb (Deputy Commissioner) Tania Thomas (Deputy Commissioner)	[N/A]

### Crown agents

Crown agents are entities whose functions pose high strategic, policy, contractual or fiscal risk, and are therefore subject to a significant degree of Ministerial control.

To reflect that closeness, the main governance and accountability arrangements are:

- Crown agents must give effect to the government policy when directed by the Minister (although this can be qualified by other legislation)
- the Minister appoints the board members for a renewable term of up to three years
- in general terms, board members serve at the pleasure of the Minister
- the Minister sets board members' fees (in accordance with the fees framework under the Act).

<sup>5</sup> As at October 2008

## **The Crown Health Financing Agency (CHFA)**

The Crown Health Financing Agency (CHFA) replaced the Residual Health Management Unit (RHMU) in 2005. RHMU was established under the Health Sector (Transfers) Act 1993 to assume responsibility for Area Health Board assets and liabilities that were not otherwise vested with Crown health enterprises, regional health authorities or the Ministry of Health. RHMU was subsequently continued under section 57 of the NZPHD Act.

The CHFA has three main functions:

- providing loan facilities to DHBs
- property advice and assisting DHBs to dispose of surplus property
- managing residual assets and liabilities (including outstanding legal claims) relating to area health boards.

DHBs are not authorised to borrow from the private sector except for working capital for facilities. The CHFA was appointed as the Crown's lender to the DHB sector in June 2001. It provides DHBs with a range of term loan facilities broadly similar to a commercial lending organisation, and has established loan application, credit assessment and monitoring procedures. The CHFA has to approve DHB business cases before funds are provided, sets the terms and conditions of loans, and ensures repayment and compliance with loan conditions.

The CHFA assists the DHB sector to dispose of surplus property either by buying surplus DHB property assets (and selling them on the open market) or by holding properties, and managing them until disposal. The CHFA also provides strategic advice to the health sector concerning property disposal and other related transactions.

The CHFA assessment of contingent liabilities as at June 2008 is \$30.2 million, relating to 328 active claims (the sum of psychiatric patients' claims and Greenlane Heart Library claims). The total amount sought under both claims to date is \$150.2 million.

The CHFA is funded by Vote Health. Its 2008/09 baseline funding is \$1.751 million. The CHFA board can have up to five members (including office holders) and currently has this number. There is no deputy chair at present.

## **Health Research Council of New Zealand (HRC)**

The Health Research Council of New Zealand (HRC) was established by the Health Research Council Act 1990. It is the main government agency for funding and co-ordinating health research and fostering the health research workforce.

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

The HRC's Vote Health baseline funding is \$0.3 million, and their Vote Research, Science and Technology funding (for research grants) is \$74 million, for the 2008/09 year. The HRC board is required to have 10 members (including office holders) – five researcher members and five non-researcher members.

## **Health Sponsorship Council (HSC)**

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

The HSC has developed four health brands ('Smokefree/Auahi Kore', 'SunSmart', 'Feeding Our Futures' and 'Problem Gambling'). It is a key contributor to the 'Quit' and 'Me Mutu' messages, and had a central role in developing the national Quitline service.

The HSC is funded by a three-year contract with the Ministry of Health (\$13.4 million in 2008/09) which expires in June 2009. The Ministry is in the initial stages of reviewing the funding arrangements for the HSC.

The HSC board can have between three and six members (including office holders) and currently has six.

## **New Zealand Blood Service (NZBS)**

The New Zealand Blood Service (NZBS) was established in 1998 to set up an integrated national blood transfusion service, which is now in place. It continues to be responsible for managing the donation, collection, processing and supply of blood, blood products and related services. The NZBS's core activity is the safe, timely, high-quality and efficient provision of blood, and tissue typing services.

The NZBS operates on a statutory breakeven basis. Its expected total revenue in 2008/09 is \$96.5 million, mainly from DHBs (on a fee for service basis). The NZBS board can have up to seven members (including office holders) and currently has five.

## **Pharmaceutical Management Agency (Pharmac)**

Pharmac was established in 1993. Pharmac is a Crown entity whose primary objective is to secure the best health outcomes that are reasonably achievable from pharmaceutical treatment, within the funding provided. All decisions relating to Pharmac's operation are made by, or under the authority of, the Pharmac Board.

The Pharmac Board has up to six members appointed by the Minister. The Board sets the strategic direction of Pharmac and may decide which community pharmaceuticals should be subsidised, at what levels and whether any special conditions might apply. They make this decision with input from their expert clinical advisory group, the Pharmacology and Therapeutics Advisory Committee (PTAC). The Board may also determine national prices for some pharmaceuticals to be purchased by, and used in, DHB hospitals.

Subsidised community pharmaceuticals are listed on the Pharmaceutical Schedule (the Schedule). Pharmaceutical suppliers may apply to Pharmac to have a medicine listed on the Schedule once a product has been registered. The Schedule lists around 3000 publicly funded prescription medicines and related products.

Community pharmaceuticals are funded from the Community Pharmaceutical Budget. This budget must be approved by the Minister of Health based on advice from DHBs and Pharmac. The Community Pharmaceuticals Budget for 2008/09 is \$653 million.

As a Crown Agent, Pharmac must give effect to government policy when directed by the Minister of Health. However, Pharmac cannot legally be directed to purchase a pharmaceutical from a particular source or at a particular price, or to provide any pharmaceutical or pharmaceutical subsidy or other benefit to a named individual [section 65(3) of the NZPHD Act refers].

In addition to administering the Pharmaceutical Schedule, and consistent with its statutory functions, Pharmac has several other functions:

- promoting the responsible use of medicines, for example the One Heart Many Lives campaign
- managing the exceptional circumstances scheme which allows for medicines not normally subsidised to be funded for rare and unusual conditions
- administering a range of very high-cost medicines.

Pharmac's Vote Health baseline funding is \$12 million for the 2008/09 year.

### **Autonomous Crown entities**

In the 'middle ground' between Crown agents and independent Crown entities, these organisations are subject to a lesser degree of Ministerial control than Crown agents.

Governance and accountability arrangements include:

- autonomous Crown entities must **have regard** to government policy when directed by the Minister
- the Minister appoints the board members for a renewable term of up to three years
- board members may be dismissed by the Minister for 'just cause'
- the Minister sets board members' fees.

### **Alcohol Advisory Council of New Zealand (ALAC)**

Established under the Alcoholic Liquor Advisory Council Act 1976, ALAC's primary objective is to encourage and promote moderation in the use of alcohol, and to develop and promote strategies that will reduce alcohol-related harm in New Zealand. It is funded by a levy on alcohol, which is expected to be \$12.7 million in 2008/09. The ALAC board must have eight members (including office holders).

### **Mental Health Commission (MHC)**

The Mental Health Commission (MHC) was established in 1998 in response to the recommendations of the Mason Inquiry into Mental Health Services. The term of the Commission was due to end in 2007, but was extended under the Mental Health Commission Act 2007 until August 2015.

The MHC acts as an advocate for the interests of people with mental illness and their families, and aims to promote better understanding of, and reduce the stigma and discrimination associated with, mental illness. The MHC also monitors implementation of the national mental health strategy and supports the development of integrated, effective, and efficient mental health services that meet the needs of service users and their families.

The MHC's Vote Health baseline funding is \$2.8 million for the 2008/09 year. The MHC must have three members (including office holders).

## **Independent Crown entities**

These organisations typically have monitoring functions, where a high level of decision-making independence from Ministers is necessary. For this reason, they are not subject to influence or easy dismissal by Ministers, and they are not required to give effect or have regard to government policy.

Governance and accountability arrangements include:

- board members or office-holders are appointed by the Governor-General on the advice of the Minister
- board members or office-holders may be dismissed by the Governor-General for just cause, on the advice of the Minister in consultation with the Attorney-General
- appointments are for five-year renewable terms
- the Remuneration Authority sets members' or office-holders' fees.

## **Health and Disability Commissioner (HDC)**

The office of the Health and Disability Commissioner (HDC) was established under its own Act in 1994. The HDC aims to promote and protect the rights of consumers of health and disability support services as specified in the Code of Health and Disability Services Consumers' Rights. The HDC is also responsible for facilitating fair and simple resolution of complaints.

The HDC may, on his or her own initiative or at the Minister's request, advise on any matter relating to the rights of health and disability consumers, the administration of the Health and Disability Commissioner Act 1994 or the need for action to protect the rights of consumers. The HDC also administers nationwide advocacy services, to promote the Code of Health and Disability Services Consumers' Rights and work alongside consumers to help 'put things right'.

The HDC's Vote Health baseline funding is \$8.99 million for the 2008/09 year. The Commissioner is appointed by the Governor-General on the recommendation of the Minister. Two Deputy Commissioners are appointed the same way but including consultation with the Commissioner. The first term of office of one of the Deputy Commissioner's expires on 1 March 2009.



## How the System Works Together

Given the size, scale and scope of the health and disability system, all participants need to work well together to ensure effective functioning. The Minister and Ministry of Health provide leadership and work with DHBs, PHOs, NGOs, Crown entities, clinicians and others across the system. There are also DHB-led joint entities such as District Health Boards New Zealand (DHBNZ). The funding and accountability arrangements provide mechanisms to drive performance and service delivery across the system.

### Funding arrangements

The system is funded mainly from Vote Health. However there are other significant funding sources, such as other government agencies (most notably ACC), local government, and private sources such as insurance and out of pocket payments. Figure 4 (opposite) shows the flow of funding through the health and disability system.

**Table 1:** Total funds across the New Zealand health system (2008/09)

Vote Health	\$12,239 million
Other Government health spending (estimate)	\$2,000 million
Local government (estimate)	\$1,500 million
Private insurance and out of pocket payments (estimate)	\$3,700 million
<b>Total spending on Health in New Zealand</b>	<b>\$19,439 million</b>

### Vote: Health funding

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

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

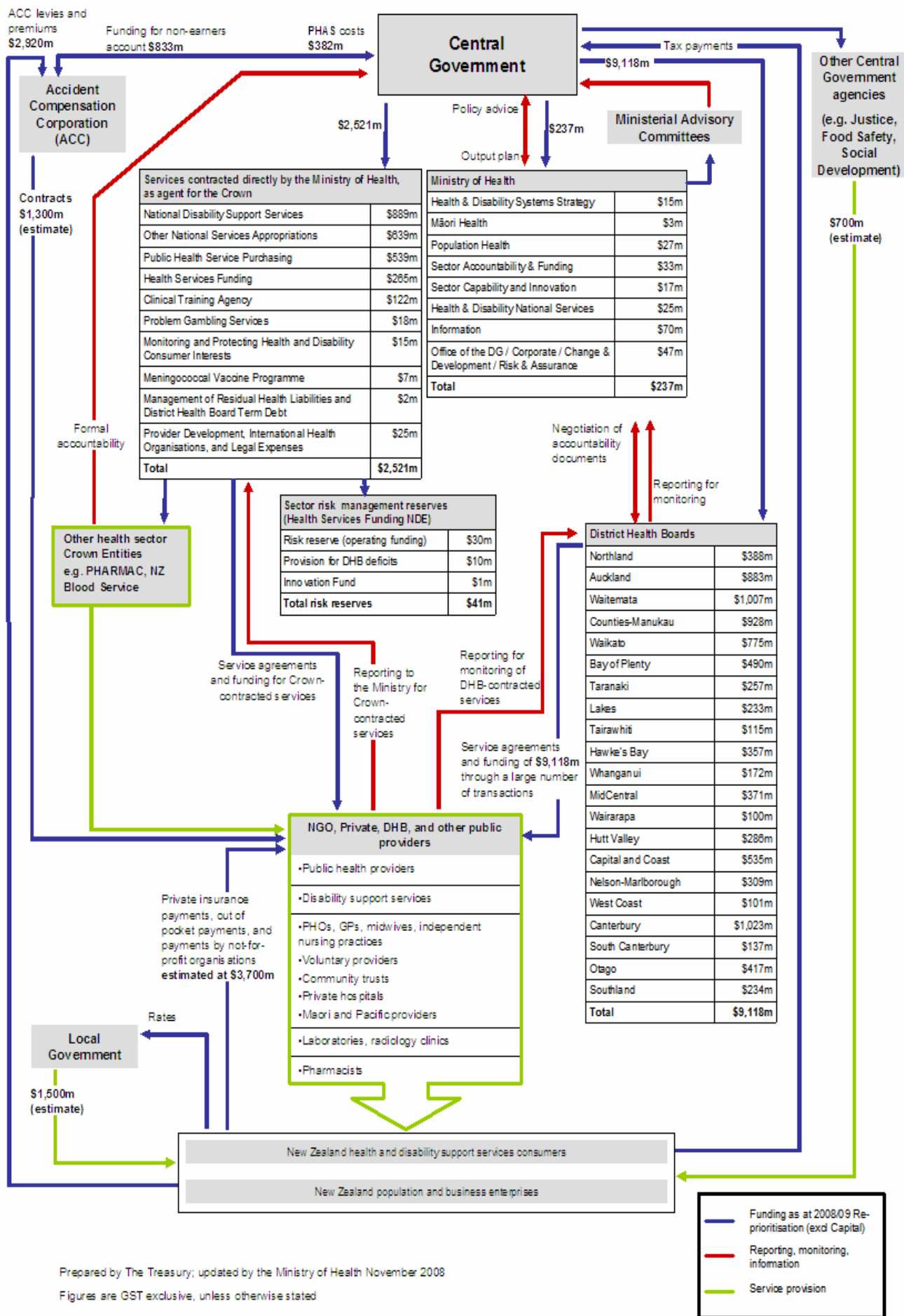
**Table 2:** Budget 2008 Vote Health funding allocation<sup>6</sup>

Type of allocation	\$ (billion)	%
Ministry departmental expenditure	\$0.227	1.9%
Ministry non-departmental expenditure	\$2.737	22.4%
District Health Boards (DHBs) funding	\$9.032	73.8%
Capital expenditure	\$0.244	2.0%
<b>Total</b>	<b>\$12.240</b>	<b>100%</b>

<sup>6</sup> Budget 2008 main estimates.



**Figure 4: New Zealand health and disability system funding flow**



This shows that of the \$12.240 billion in Vote: health, \$227 million (or around 1.9%) is used directly by the Ministry of Health, while the majority of funding is used to purchase or fund health and disability services either directly by the Ministry or via DHBs.

### **Ministry of Health direct funding of services (NDE)**

The Ministry of Health directly funds national services, including disability support services, clinical training and a wide range of personal and public health services, as described in other parts of this paper.

### **DHB funding**

The Service Coverage Schedule outlines the national minimum range and standard of services to be publicly funded, and DHBs are required to ensure their populations have access to all these services. DHBs may provide the services directly, or contract with third parties. A DHB may also purchase some 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 used.

There are some 'ring fenced' funds, such as for mental health services, which DHBs are required to spend on nominated services. However, in general, DHBs have flexibility around the allocation of funding to specific services, and over service volumes, to reflect the needs of their populations.

Each year the majority of DHBs and the Ministry's NDE budgets are increased using a forecast funding track (FFT) and demographic (demo) adjustors. These aim to accommodate inflationary pressures, and demand pressures caused by population changes. DHB funding is distributed using a population-based funding formula (PBFF), which allocates funding based on the size and composition of each DHB's population. This means the share of new funding each DHB receives is largely determined by whether (and by how much) their population is growing or shrinking relative to others.

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

### **PHO funding**

PHOs are largely funded using a capitation based payment system. This means PHOs and their general practices receive public funding according to the number of people enrolled, not the number of times they provide a service. As people need more care at particular times (eg, very young children or older people) capitation payments vary according to the make up of enrolled populations.

### **Capital expenditure<sup>7</sup>**

The \$244 million for capital projects includes funding carried forward from previous years and new funding. It is part of a \$940 million multi-year envelope for approved and pending capital expenditure. Of the \$940 million, \$780 million is for DHB projects (\$580 million for projects approved and under way and \$200 million for allocation to

<sup>7</sup> Figures as at April 2008

DHBs in the 2008 annual capital allocation round). The remainder covers the oral health investment programme and Ministry of Health assets.

## **DHB performance and accountability arrangements**

In this devolved funding environment DHBs make decisions on the mix, level and quality of health and disability services, within the parameters of the nationwide minimum service coverage requirements and safety standards. The New Zealand Public Health and Disability Act and the Crown Entities Act require five accountability documents:

- **District Strategic Plans (DSPs)** covering a 5–10 year period, which must be reviewed at least once every three years. DHBs must obtain the consent of the Minister before making significant amendments to their DSP. The next DSPs are due to the Ministry of Health early in 2010.
- **Statements of Intent (SOIs)** are developed annually to cover at least three years. DHBs are accountable to Parliament via their SOIs, and they must be tabled with Parliament at the beginning of the financial year.
- **District Annual Plans (DAPs)** set out what DHBs intend to do over the next financial year to achieve the longer term goals in the DSP. They include how funding will be allocated across services and what targets and indicators will be used to measure performance. DAPs are agreed with the Minister under the NZPHD Act section 39, and should be signed off by the Minister by June each year.
- **Crown Funding Agreements (CFAs)** between the Minister and each DHB, which contain DHB specific agreed performance targets as well as nationwide minimum service coverage and safety standards.
- **Annual Reports** that set out the DHB's performance in achieving the goals, indicators and targets set out in their DAPs, and how the funding was actually allocated.

The DSP, DAP and CFA are accountability documents between a DHB and the Government. The DAP and CFA are agreed on by a DHB and the Minister. A DHB obtains the Minister's consent to its DSP. A DHB is also responsible to its local community and must consult with the community on its DSP. The SOI and Annual Report establish DHBs' accountability to Parliament. The Minister of Finance also has an interest in the DHB DAPs, which means the Minister of Finance's agreement is required prior to the approval of the DAPs by the Minister of Health.

## **The DHB planning and funding packages**

A key aspect in setting performance expectations, under the DHB accountability framework, is the development and release of an annual planning package. The DHB planning package contains agreed planning guidelines for the accountability documents described above, up-to-date policy, service coverage standards, performance targets and indicators. This is to ensure that planning appropriately reflects the service frameworks and policy priorities of the Minister of Health.

DHBs and other stakeholders are consulted on the development of the planning package during September and October each year, followed by formal endorsement of the package by the Minister. The planning package is usually sent to DHBs in

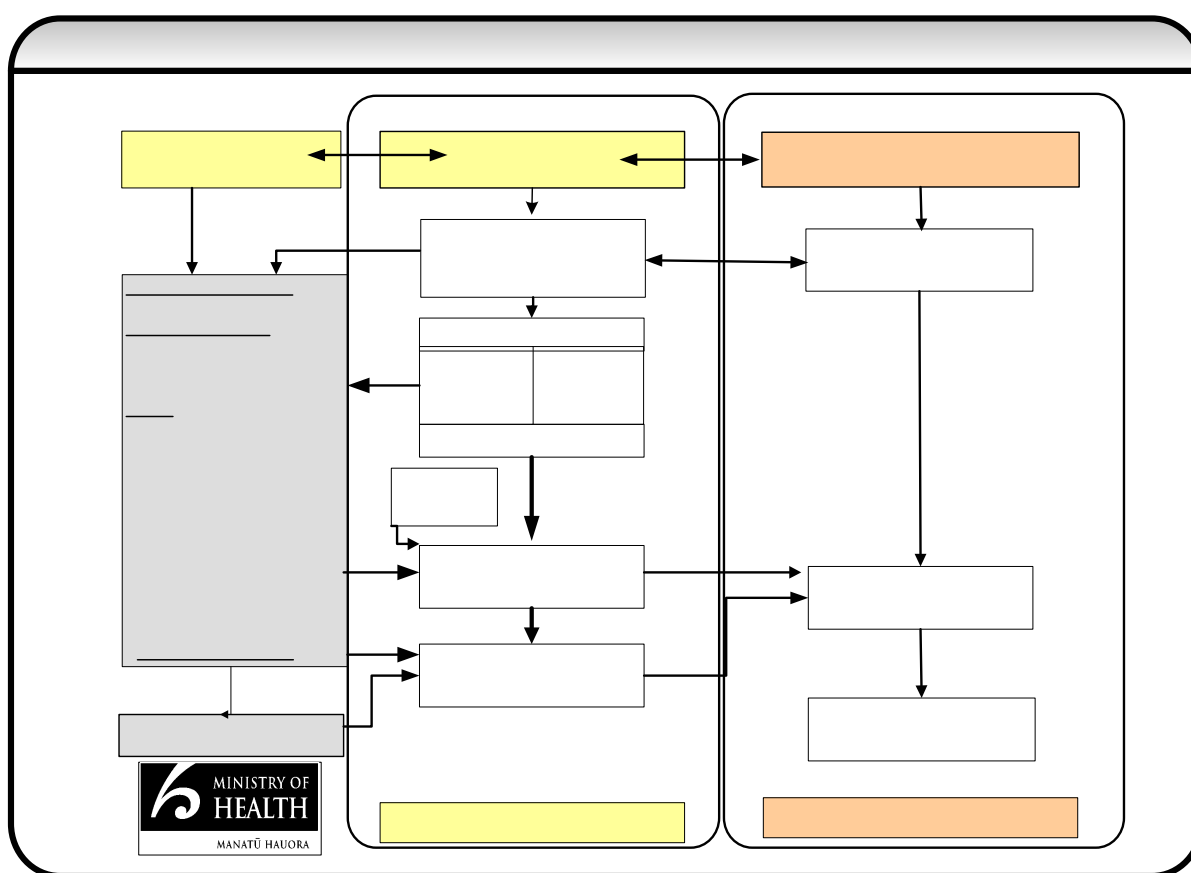
December to allow sufficient time for DHBs to robustly embed new priorities in their planning processes.

The DHB funding package is also timetabled for release in December. The DHB funding package includes the expected appropriation funding plus the forecast inter-district flow payments. Each DHB is sent an individual letter plus a supporting spreadsheet showing the calculations and results for all DHBs.

### The Minister's letter of expectations

The Government's key priorities for each year are conveyed to DHBs via a 'letter of expectations' from the Minister. This is sent to DHBs with the planning package to ensure the Minister's priorities are addressed in the resulting accountability documents.

**Figure 5:** DHB accountability framework



These arrangements reflect a funding environment where:

- a population based funding formula (known as PBFF) determines the share of funding to be allocated to each DHB, based on the population living in the District. The formula includes adjustors for population age and other indicators of high needs.
- DHBs have responsibility for making decisions on the mix, level and quality of health and disability services, within the parameters of national strategies and nationwide minimum service coverage and safety standards.
- the Ministry of Health, as agent of the Minister, defines nationwide service coverage, safety standards, and the operating environment. The Minister enters into CFAs with DHBs, and may exercise reserve powers in the case of repeated performance failure.

## **Monitoring DHBs' performance**

The Ministry receives monthly information on DHBs' financial performance against targets agreed in the DAP, and quarterly reporting against its CFA. All information is assessed, reports are sent to the Minister, and feedback is provided to DHBs.

A Monitoring and Intervention Framework (MIF) enables performance management of specific DHBs if required. This framework continues to be further enhanced. Increasingly intensive levels of monitoring and where necessary, intervention are available to the Ministry and Minister of Health via the MIF, if needed to ensure that poor performance is addressed. The MIF scale comprises:

- 1 standard monitoring
- 2 performance watch
- 3 intensive monitoring
- 4 intermediate governance action
- 5 direct governance action.

The Ministry can move DHBs between levels one and three, but the Minister must be involved in decisions at levels four and five. The MIF provides clear guidance on:

- triggers for moving up and down levels
- actions required by the Ministry and the DHB at each level
- potential consequences of being at each level.

## **District Health Boards New Zealand (DHBNZ)**

DHBs have formed a national umbrella organisation called District Health Boards New Zealand Incorporated (DHBNZ). It co-ordinates joint DHB initiatives and communicates with government and the Ministry over matters that affect all DHBs. There is no statutory relationship between the Crown and DHBNZ. Membership of DHBNZ is voluntary for DHBs and most, but not all, DHBs are members.

DHBNZ leads employment relations strategy development (both broadly and in respect of specific negotiations), information collation and analysis, and provides advocacy in national and regional bargaining activity on behalf of DHBs. Final decision-making on proposed MECA settlements remains with individual DHB CEs. DHBNZ also runs particular programmes, including a PHO performance management programme.

DHBNZ provides a forum for DHBs to develop a strategic view on key policy and operational issues, and to provide DHBs with a shared capacity to:

- develop national service frameworks for pricing, contracting, service development and specifications
- facilitate the sharing of project resources
- identify and promote best practice
- consider strategies for workforce planning and development
- provide analysis and advocacy on industrial relations issues (including national collective bargaining)

- co-ordinate DHB planning and funding activities where required.

## **DHB and Clinician-led collaboration and planning**

A number of co-ordinated service planning arrangements are being developed by DHBs or clinicians across geographic areas. A draft clinical services plan for the six DHBs in the central region has been developed by their shared service agency (the Central Regional Technical Support Agency (TAS)), as has the first phase of a Northern regional plan. At the subregional level, Southland and Otago DHBs have merged a range of administrative and financial services. There is also coordinated service action within particular service areas, as clinical networks are developed.

## **Shared services agencies**

Four shared services agencies allow DHBs to pool their resources to obtain common support services through jointly owned companies. These are:

- the Northern DHB support agency
- Health Share Ltd (based in the Waikato)
- Central Regional Technical Support Agency (TAS)
- South Island Shared Service Agency Ltd (SISAL)

Services provided include health service and funding planning, a range of information and analysis services and provider audit functions. In addition these agencies have provided a platform for further collaborative planning as described above.

## **Clinical networks**

Clinical networks have the potential to improve patient outcomes through better systems and sharing expertise and innovation. They offer peer support for health practitioners who may otherwise be geographically isolated from each other. For example, the Cancer Control Initiative has resulted in four regional cancer networks covering New Zealand. The networks take a 'continuum of care' approach to service planning and are undertaking patient mapping to identify problems with how patients access the system, how they typically proceed through it, and how this can be made easier.

The Ministry is establishing a framework for the ongoing development of clinical networks that will build on experience to date with the cancer, burns and mental health networks.

## **Employment relations**

DHB Chief Executives (CEs) have the authority to enter into collective or individual employment agreements covering DHB employees. CEs' 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% of all DHB employees, while seven regional MECAs cover a further



20%. The balance of DHB employees are covered by local collective or individual employment agreements.

Union density (membership as a proportion of the workforce) is very high (over 80%) in DHBs. The unions representing DHB employees include a mix of health sector-specific (typically occupational) unions and general unions. There is some overlapping coverage where two or more unions separately represent the same occupational group.

Union density in the non-DHB health workforce is lower than in DHBs. MECAs exist for nurses and administrative staff in primary health providers, and for hospice staff (both negotiated by the New Zealand Nurses Organisation (NZNO)). Bargaining to cover Māori and iwi health care providers and approximately 200 non-collectivised aged-care providers has also been initiated. Several larger providers in the aged care and disability support services sectors have single-employer collective agreements in place.

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

Under the NZPHD Act, CEs must consult with the Director-General of Health prior to finalising the terms and conditions of a collective agreement (Schedule 3, cl.44(2)-(4)). These obligations are explained further by specific Ministry guidelines (December 2007) and the Operational Policy Framework document. The Ministry has no direct statutory role in health sector bargaining outside of DHBs, although the Ministry can explicitly or indirectly influence pay setting through its funding role.

The Ministry of Health's key roles in health sector employment relations activity are to liaise and provide information, advice and feedback to the Minister of Health, other government agencies and DHBs on employment relations activities and risks.

### **Health Sector Relationship Agreement (HSRA)**

A tripartite Health Sector Relationship Agreement (HSRA) between the Minister and the Ministry of Health, the DHBs, the Combined Trade Union (CTU) and their major health affiliates (NZNO, Association of Salaried Medical Specialists, Public Service Association and Service and Food Workers' Union) was signed on 1 September 2008. The HSRA reflects a commitment to constructive engagement and provides a framework and work programme that aims to assist in improving productivity, efficiency and effectiveness in health service delivery, while acknowledging resource constraints.



## International Linkages

New Zealand's Ministry of Health maintains active links with international health organisations and other Health Ministries in relevant countries, to achieve the following goals:

- To protect New Zealand against international health threats such as pandemic influenza
- To learn from other countries experiences, and international debate, on ways to organise, manage and deliver health services, including best practice and new innovations. New Zealand also contributes data to international organisations (eg, the World Health Organisation, the Organisation for Economic Cooperation and Development and the Commonwealth Fund) to benchmark New Zealand's performance against other countries
- To provide support and assistance to less developed countries, in particular in the Pacific region. This demonstrates that New Zealand is a good global citizen, and recognises that health in Pacific nations strongly impacts on the health of Pacific populations in New Zealand.

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

### International contacts

The World Health Organization (WHO) is the primary global agency for international health activity. It is a forum for debate on issues such as the performance of health systems, improved surveillance methods, reporting and control of communicable diseases, and ways to reduce non-communicable diseases. New Zealand belongs to the Western Pacific Regional Office (WPRO) of the WHO, and is currently a representative of the Western Pacific Region on the WHO executive board.

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

New Zealand has signed 'arrangements for health co-operation' with the health Ministries (or equivalent) of China, British Colombia and recently with the Cook Islands.

### The Commonwealth

New Zealand maintains an active link with health Ministers and authorities elsewhere in the Commonwealth. Regular Commonwealth Health Ministers Meetings occur prior to the World Health Assembly in Geneva, Switzerland, in May each year.

### Australia

Meetings with Australian Ministers of Health occur regularly at the federal, state and territory levels, under the auspices of the Australian Health Ministers' Conference. This provides a forum for Ministers to discuss issues of mutual interest and is supported by the Australian Health Ministers' Advisory Council, made up of chief executives from the states, territories and federal (Commonwealth) Department of Health.

## **Pacific Links**

Hosted by WHO and the Secretariat of the Pacific Community (SPC), Pacific Health Ministers meet every two years to consider regional initiatives and collaboration on existing or emerging health issues. New Zealand and Australia are invited as observers to the meetings. The next meeting will be in March 2009 in Papua New Guinea.

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

## **International conventions**

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

### **The framework convention on tobacco control**

The framework convention on tobacco control is the WHO's first international treaty. The World Health Assembly adopted the text in May 2003, and it came into force on 28 February 2005. Currently 160 member countries of the WHO are party to it. New Zealand participated actively in its development, signed it in June 2003, and ratified it in January 2004. It is a relatively strong convention covering such issues as tobacco advertising, price and tax measures, and packaging and labelling of tobacco products.

### **The International Health Regulations (IHR)**

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

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

The Public Health Bill, proposed to replace the Health Act 1956, would be the main statutory instrument for fully giving effect to New Zealand's obligations under the IHR.

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

### **Other agreements**

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

## Glossary

ACART	Advisory Committee on Assisted Reproductive Technologies
ACC	Accident Compensation Corporation
ALAC	Alcohol Advisory Council of New Zealand
CFA	Crown Funding Agreement
CHFA	Crown Health Financing Agency
CYMRC	Child and Youth Mortality Review Committee
DAP	District Annual Plan
Demo	Demographic adjustor
DHB	District Health Board
DHBNZ	District Health Boards New Zealand
DSP	District Strategic Plan
ECART	Ethics Committee on Assisted Reproductive Technologies
QIC	Quality Improvement Committee
FFT	Forecast Funding Track
FSANZ	Food Standards Australia New Zealand
HDC	Health and Disability Commissioner
HDECs	Regional Health and Disability Ethics Committees
HealthPAC	Health Payments, Agreements and Compliance (Ministry of Health)
HISAC	Health Information Strategy Advisory Committee
HPCA Act	Health Practitioners Competency Assurance Act
HRC	Health Research Council of New Zealand
HSC	Health Sponsorship Council
HSRA	Health Sector Relationship Agreement
IHR	International Health Regulations
MAAC	Medicines Assessment Advisory Committee
MARC	Medicines Adverse Reactions Committee
MCC	Medicines Classification Committee
Medsafe	New Zealand Medicines and Medical Devices Safety Authority (Ministry of Health)
MHC	Mental Health Commission
MHRT	Mental Health Review Tribunal
MIF	Monitoring and Intervention Framework
MRC	Medicines Review Committee
NCSR	National Cancer Screening Register (Ministry of Health)

NEAC	National Ethics Advisory Committee
NGOs	Non-Governmental Organisations
NHC	National Health Committee
NPAC	New Prescribers Advisory Committee
NRL	National Radiation Laboratory
NSDP	National Systems Development Programme
NZBS	New Zealand Blood Service
NZFSA	New Zealand Food Safety Authority
NZHIS	New Zealand Health Information Service (Ministry of Health)
NZNO	New Zealand Nurses Organisation
NZPHD Act	New Zealand Public Health and Disability Act 2000
OPF	Operational Policy Framework
PBFF	Population Based Funding Formula
PGD Act	Plumbers, Gasfitters and Drainlayers Act 1976
PGD Board	Plumbers, Gasfitters and Drainlayers Board
PHARMAC	Pharmaceutical Management Agency
PHO	Primary Health Organisation
PHU	Public Health Unit
PMMRC	Perinatal and Maternal Mortality Review Committee
RHMU	Residual Health Management Unit
RPAC	Radiation Protection Advisory Council
SOI	Statement of Intent
SPC	Secretariat of the Pacific Community
WHO	World Health Organization

## Appendix 1: Health Legislation

<b>Alcohol Advisory Council Act 1976</b>	<p>This Act established the Alcoholic Liquor Advisory Council to promote moderation in alcohol use and reduce the personal, social, and economic harm resulting from its misuse. The Act defines the Council's functions and powers, and provides for its funding by a levy on alcoholic liquor.</p> <p><b>Responsible directorate:</b> Sector Accountability and Funding</p>
<b>Alcoholism and Drug Addiction Act 1966</b>	<p>This Act provides for the care and treatment of people with alcohol and drug addictions.</p> <p><b>Responsible directorate:</b> Population Health (Mental Health)</p>
<b>Burial and Cremation Act 1964</b>	<p>This Act outlines the law relating to the burial and cremation of the dead.</p> <p><b>Responsible directorate:</b> Population Health</p>
<b>Cancer Registry Act 1993</b>	<p>This Act provides for the compilation of a statistical record of the incidence of cancer in its various forms, as a basis for better direction of programmes for research and for cancer prevention.</p> <p><b>Responsible directorate:</b> Population Health and Information directorates (Sector Services, Clinical Coding)</p>
<b>Children's Health Camp Dissolution Act 1999</b>	<p>This Act dissolved the Children's Health Camps Board, transferred its assets and liabilities to a foundation incorporated under Part 2 of the Charitable Trusts Act 1957, and provides for incidental matters.</p> <p><b>Responsible directorate:</b> Population Health</p>
<b>Disabled Persons Community Welfare Act 1975, Part 2A</b>	<p>This Act sets out the right of persons in residential care to review of the adequacy of any disability services, and whether or not a person's disability services needs are appropriately met by the residential care received.</p> <p><b>Responsible directorate:</b> Population Health</p>
<b>Epidemic Preparedness Act 2006</b>	<p>This Act provides statutory power for government agencies to prevent and respond to the outbreak of epidemics in New Zealand, and to respond to particular possible consequences of epidemics (whether occurring in New Zealand or overseas). This Act also aims to ensure that certain activities can continue during an epidemic in New Zealand, and to enable the relaxation of some statutory requirements that might not be capable of being complied with, or complied with fully, during an epidemic.</p> <p><b>Responsible directorate:</b> Population Health</p>
<b>Health Act 1956</b>	<p>The current law relating to public health (as described on page 4).</p> <p><b>Responsible directorate:</b> Health and Disability Systems Strategy, Population Health</p>
<b>Health and Disability Commissioner Act 1994</b>	<p>This Act aims to promote and protect the rights of health consumers and disability services consumers to secure fair, simple, speedy, and efficient resolution of complaints. It provides for the appointment of a Health and Disability Commissioner to investigate complaints, and defines the Commissioner's functions and powers. It also provides for the establishment of a Health and Disability Services Consumer Advocacy Service, and for the promulgation of a Code of Health and Disability Services Consumers' Rights.</p> <p><b>Responsible directorate:</b> Health and Disability Systems Strategy (Workforce)</p>

<p><b>Health and Disability Services (Safety) Act 2001</b></p>	<p>This Act aims to:</p> <ul style="list-style-type: none"> <li>(a) promote the safe provision of health and disability services to the public</li> <li>(b) enable the establishment of consistent and reasonable standards for providing health and disability services to the public safely</li> <li>(c) encourage providers of health and disability services to take responsibility for providing those services to the public safely</li> <li>(d) encourage providers of health and disability services to the public to improve continuously the quality of those services.</li> </ul> <p><b>Responsible directorate:</b> Sector Accountability and Funding (HealthCert)</p>
<p><b>Health Benefits (Reciprocity with Australia) Act 1999</b></p>	<p>This Act provides for reciprocity with Australia in relation to pharmaceutical, hospital, and maternity benefits.</p>
<p><b>Health Benefits (Reciprocity with United Kingdom) Act 1982</b></p>	<p>This Act provides for reciprocity with the United Kingdom in relation to medical, hospital, and related benefits.</p>
<p><b>Health Practitioners Competence Assurance Act 2003</b></p>	<p>This Act aims to ensure health practitioners are competent and fit to practice their professions. It provides:</p> <ul style="list-style-type: none"> <li>(a) for a consistent accountability regime for all health professions</li> <li>(b) for the determination of the scope of practice within which each health practitioner is competent</li> <li>(c) for systems to ensure that no health practitioner practises outside his or her scope of practice</li> <li>(d) for power to restrict specified activities to particular classes of health practitioner</li> <li>(e) for certain protections for health practitioners who take part in protected quality assurance activities.</li> </ul> <p>Note that additional health professions may become subject to this Act.</p> <p><b>Responsible directorate:</b> Health and Disability Systems Strategy (Workforce)</p>
<p><b>Health Research Council Act 1990</b></p>	<p>This Act defines the functions and powers of the Health Research Council of New Zealand.</p>
<p><b>Health Sector (Transfers) Act 1993</b></p>	<p>The purposes of this Act are to:</p> <ul style="list-style-type: none"> <li>(a) provide for assets, liabilities, or functions within the public health and disability sector to be transferred to the Crown or to certain specified bodies within that sector</li> <li>(b) provide for the effect and the consequences of <ul style="list-style-type: none"> <li>(i) transfers, in accordance with this Act, of assets, liabilities, or functions within the public health and disability sector</li> <li>(ii) sales or other dispositions of land by DHBs</li> </ul> </li> <li>(c) permit DHBs, subject to specified conditions, to sell or dispose of land that is subject to trusts or certain other restrictions</li> </ul> <p><b>Responsible directorate:</b> Sector Accountability and Funding</p>
<p><b>Human Tissue Act 2008</b></p>	<p>This Act governs the collection and use of human tissue to ensure that it is done in an appropriate way, without endangering the health and safety of members of the public and does not involve payment.</p> <p><b>Responsible directorate:</b> Health and Disability Systems Strategy</p>
<p><b>Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003</b></p>	<p>This Act provides for the compulsory care and rehabilitation of individuals with an intellectual disability who have been charged with, or convicted of, an imprisonable offence.</p>

<b>Medicines Act 1981</b>	<p>This Act covers the law relating to the manufacture, sale, and supply of medicines, medical devices, and related products.</p> <p><b>Responsible directorate:</b> Sector Accountability and Funding (Medsafe)</p>
<b>Mental Health Commission Act 1998</b>	<p>This Act established the Mental Health Commission to implement the national mental health strategy and improve services and outcomes for people with mental illness and their families and caregivers.</p> <p><b>Responsible directorate:</b> Population Health (Mental Health)</p>
<b>Mental Health (Compulsory Assessment and Treatment) Act 1992</b>	<p>This Act defines the circumstances and conditions where persons may be subjected to compulsory psychiatric assessment and treatment. It defines and protects the rights of such persons, and generally defines the law relating to the assessment and treatment of persons suffering from mental disorders.</p> <p><b>Responsible directorate:</b> Population Health (Mental Health)</p>
<b>Misuse of Drugs Act 1975</b>	<p>This Act provides for the prevention of the misuse of drugs.</p> <p><b>Responsible directorate:</b> Population Health (Harm Minimisation)</p>
<b>New Zealand Public Health and Disability Act 2000</b>	<p>The key piece of legislation in the health and disability system, this Act provides for the public funding and provision of personal health services, public health services, and disability support services, and establishes the publicly-owned health and disability organisations.</p> <p>This Act is covered in more detail in the body of this paper.</p>
<b>Radiation Protection Act 1965</b>	<p>An Act to consolidate and amend the Radioactive Substances Act 1949.</p> <p><b>Responsible Directorate:</b> Sector Accountability &amp; Funding (National Radiation Laboratory)</p>
<b>Smoke-free Environments Act 1990</b>	<p>This Act 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 smoking by others</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> <li>(d) establish a Health Sponsorship Council</li> </ul> <p><b>Responsible Directorate:</b> Sector Capability &amp; Innovation (Tobacco Control)</p>
<b>Tuberculosis Act 1948</b>	<p>This Act provides for the treatment, care, and assistance of persons suffering or having suffered from tuberculosis, and for preventing the spread of tuberculosis.</p> <p><b>Responsible Directorate:</b> Population Health (Environmental &amp; Border Health)</p>



## **Appendix 2: Ministerial Committees, Tribunals, Councils and Inspectors**

This appendix provides a brief description of the roles, functions and statutory bases of those bodies and people the Minister of Health appoints which have not already been discussed. Some bodies also have members appointed in other ways, or by virtue of their job. The appendix is ordered alphabetically by statute of establishment.

### **The Health Act 1956**

#### **National Kaitiaki Group**

The National Kaitiaki Group is established under the Health (Cervical Screening (Kaitiaki)) Regulations. It responds to applications to use, publish or disclose Māori women's aggregate data from the National Cervical Screening Register. It meets no more than four times per year. It has five members, and Kiri Rikihana is the convenor.

#### **National Cervical Screening Programme Review Committee**

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

### **Health Practitioners Competence Assurance Act 2003**

#### **Responsible authorities**

There are currently 16 responsible authorities (often called health regulatory authorities) under the Health Practitioners Competence Assurance Act (HPCA Act) covering 21 health professions. Other health services have applied to be regulated as professions with a regulatory authority.

Each of the 16 regulatory authorities describe scopes of practice for its profession (these set the boundaries within which a practitioner can practice), prescribe necessary qualifications, register practitioners and issue annual practising certificates. They also set standards of competence. The regulatory authorities, via professional conduct committees, can investigate individual practitioners' competence and conduct.

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

While the Minister of Health currently appoints the members of all regulatory authorities there is a power in the HPCA Act for the Minister to make regulations so that a proportion of the health professional members of an authority would be appointed according to elections held among the profession.

<b>Responsible authority under the HPCA Act</b>	<b>Membership</b>
Chiropractic Board	2 lay, 5 professional members
Dental Council	3 lay, 7 professional members
Dietitians Board	2 lay, 6 professional members
Medical Laboratory Science Board	3 lay, 7 professional members
Medical Radiation Technologists Board	2 lay, 6 professional members
Medical Council	3 lay, 7 professional members
Midwifery Council	2 lay, 5 professional members
Nursing Council	3 lay, 7 professional members
Occupational Therapy Board	2 lay, 6 professional members
Optometrists and Dispensing Opticians Board	3 lay, 7 professional members
Osteopathic Council	2 lay, 6 professional members
Pharmacy Council	2 lay, 5 professional members
Physiotherapy Board	3 lay, 7 professional members
Podiatrists Board	2 lay, 5 professional members
Psychologists Board	3 lay, 7 professional members
Psychotherapy Board	2 lay, 5 professional members

### **Health Practitioners Disciplinary Tribunal**

The Health Practitioners Disciplinary Tribunal hears and determines more serious cases against health practitioners. It comprises a chair, three deputy chairs, and a panel of 131 laypeople and health practitioners. However, only the chair or a deputy, one layperson and three practitioners of the relevant profession sit on each case. The chair of the Health Practitioners Disciplinary Tribunal is Mr Bruce Corkill QC.

### **Human Assisted Reproductive Technology (HART) Act 2004**

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

The Advisory Committee on Assisted Reproductive Procedures and Human Reproductive Research (ACART) has several statutory functions, including:

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

ACART currently has 10 members. The chair is Professor Sylvia Rumball.

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

The Ethics Committee on Assisted Reproductive Technology's (ECART) functions include:

- considering and determining applications for assisted reproductive procedures or human reproductive research

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

ECART currently has ten members appointed by the Minister of Health. The chair is Ms Kate Davenport.

## **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. There are currently 14 of these district inspectors.

## **Medicines Act 1981**

### **Medicines Adverse Reactions Committee (MARC)**

The Medicines Adverse Reactions Committee (MARC) advises the Minister of Health on medicine safety issues and reviews reports on adverse reactions. It has eight members including the chair, Associate Professor Tim Maling.

### **Medicines Assessment Advisory Committee (MAAC)**

The terms of reference for this committee are to:

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

This committee and its two sub-committees have a total of 16 members, including the chair, Associate Professor Richard Robson.

### **Medicines Classification Committee (MCC)**

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

The MCC has six members including two nominees each from the New Zealand Medical Association, the Pharmaceutical Society of New Zealand, and the Ministry of Health (one of whom is required to be the chair). The current chair is Dr Stewart Jessamine.

## **Medicines Review Committee (MRC)**

The Medicines Review Committee (MRC) inquires into objections to recommendations made by the MAAC that the minister not grant consent to distribute new medicines, and considers appeals regarding clinical trials, sales of medical devices and licence applications. It has seven members including the chair, Brian Irvine.

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

### **Mental Health Review Tribunal**

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

The principal role of the Mental Health Review Tribunal (MHRT) is to consider whether or not a patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992 is fit to be released from compulsory status. There is a requirement for every person subject to a compulsory treatment order to have his or her condition reviewed at least every six months. Should a patient disagree with their responsible clinician's decision that they are not fit to be released from compulsory status, the patient is able to apply to the MHRT for a review of his or her condition. The patient can appeal an MHRT decision to the District Court or High Court.

The MHRT comprises three members: a lawyer (by convention the convenor), a psychiatrist and a community member. The current convener is Nigel Dunlop.

### **District inspectors for mental health**

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

Currently there are 29 district inspectors and five deputy district inspectors. Helen Cull QC is the Senior Advisory District Inspector for Mental Health.

## **Misuse of Drugs Act 1975**

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

The Expert Advisory Committee on Drugs (EACD):

- conducts reviews of controlled drugs and other narcotic or psychotropic substances
- recommends to the Minister of Health whether and how such substances should be classified

- increases public awareness of its work by (for instance) releasing papers, reports and recommendations.

Dr Ashley Bloomfield, the Ministry's Chief Advisor Public Health, is the chair of EACD. It has up to 11 members including those with technical knowledge, representatives of the Police and particular departments, and a consumer representative.

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

### **Cancer Control Council**

The Cancer Control Council provides an independent, sustainable focus for cancer control, leading the sector to implement the New Zealand Cancer Control Strategy, to:

- reduce the incidence and impact of cancer
- reduce inequalities with respect to cancer.

The Council reports annually to the Minister of Health and may also advise on any other matters the Minister specifies by notice to the Council.

The Cancer Control Council comprises nine members. The Principal Advisor Cancer Control (Dr John Childs) also serves as an *ex-officio* member of the Council. Dame Catherine Tizard is the chair of the Council.

### **Child and Youth Mortality Review Committee (CYMRC)**

The Child and Youth Mortality Review Committee (CYMRC) reviews the deaths of children and young people aged between 28 days and 24 years, aiming to reduce such deaths. The CYMRC is informed through a secure, cross-agency electronic information gathering process. The CYMRC's work plan for 2005/06 focuses on the further development of local mortality review processes, engagement with other relevant agencies to inform and connect review processes, and promotion of safety messages.

The CYMRC has 10 members. Professor Barry Taylor is the chair.

### **Health and disability ethics committees**

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

Each HDEC has 12 members including its chair.

### **Health Information Strategy Action Committee (HISAC)**

The Health Information Strategy Advisory Committee provides independent, strategic advice to the Minister of Health and the health sector. It assists the Minister to achieve effective governance and delivery of the Health Information Strategy by supporting collaboration and partnering of organisations and individuals across the health and disability system. It has 10 members and is chaired by Graeme Osborne.

## **National Ethics Advisory Committee**

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

The NEAC has 12 members including the chair, Dr Andrew Moore.

## **National Health Committee (NHC)**

The National Advisory Committee on Health and Disability (NHC) provides advice to the Minister of Health on the kinds and relative priorities of public health, personal health and disability support services the Committee believes should be publicly funded. It may also advise on other public health matters. The NHC has established a Public Health Advisory Sub-Committee to advise on public health issues, including promotion and monitoring.

The NHC has up to 12 members including the chair, Linda Holloway. The chair of the Public Health Advisory Committee (PHAC) is Pauline Barnett.

## **Quality Improvement Committee (QIC)**

The Quality Improvement Committee develops whole system frameworks and integrative approaches to quality improvement, and supports and develops leadership, shared learning, trust and culture change. This approach is considered most likely to speed up the implementation of innovation and best practice. It requires the Committee to be collaborative while maintaining its base principle that consumers are central.

Most recently the Committee has developed a proposal to strengthen the consumer voice on quality and it will report to you on funding options.

The Ministry will report to you on the benefits of increasing this Committee's independence as part of a larger entity that would primarily collect, analyse and report on patient safety and quality improvement data.

The Quality Improvement Committee has 13 members and is chaired by Pat Snedden.

## **Radiation Protection Act 1965**

### **Radiation Protection Advisory Council**

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

The Council comprises: the Director-General of Health, the Director of the National Radiation Laboratory and five others. Mr David Jenkins is the chair.