

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

## **Handbook of Organisations and Responsibilities**

October 2017

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# 1 Overview of the health and disability system

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

This handbook provides an overview of the health and disability system as at October 2017. It describes the major organisations and structures in the system, along with their roles, functions and responsibilities. The primary focus of this handbook is on those organisations that fall within scope of Vote Health. However, these organisations alone cannot meet all of New Zealanders' health and disability needs. Strong collaboration and cooperation across government agencies, local government, communities, families and whānau are essential to achieving good health, social and economic outcomes.

## A complex system, working together

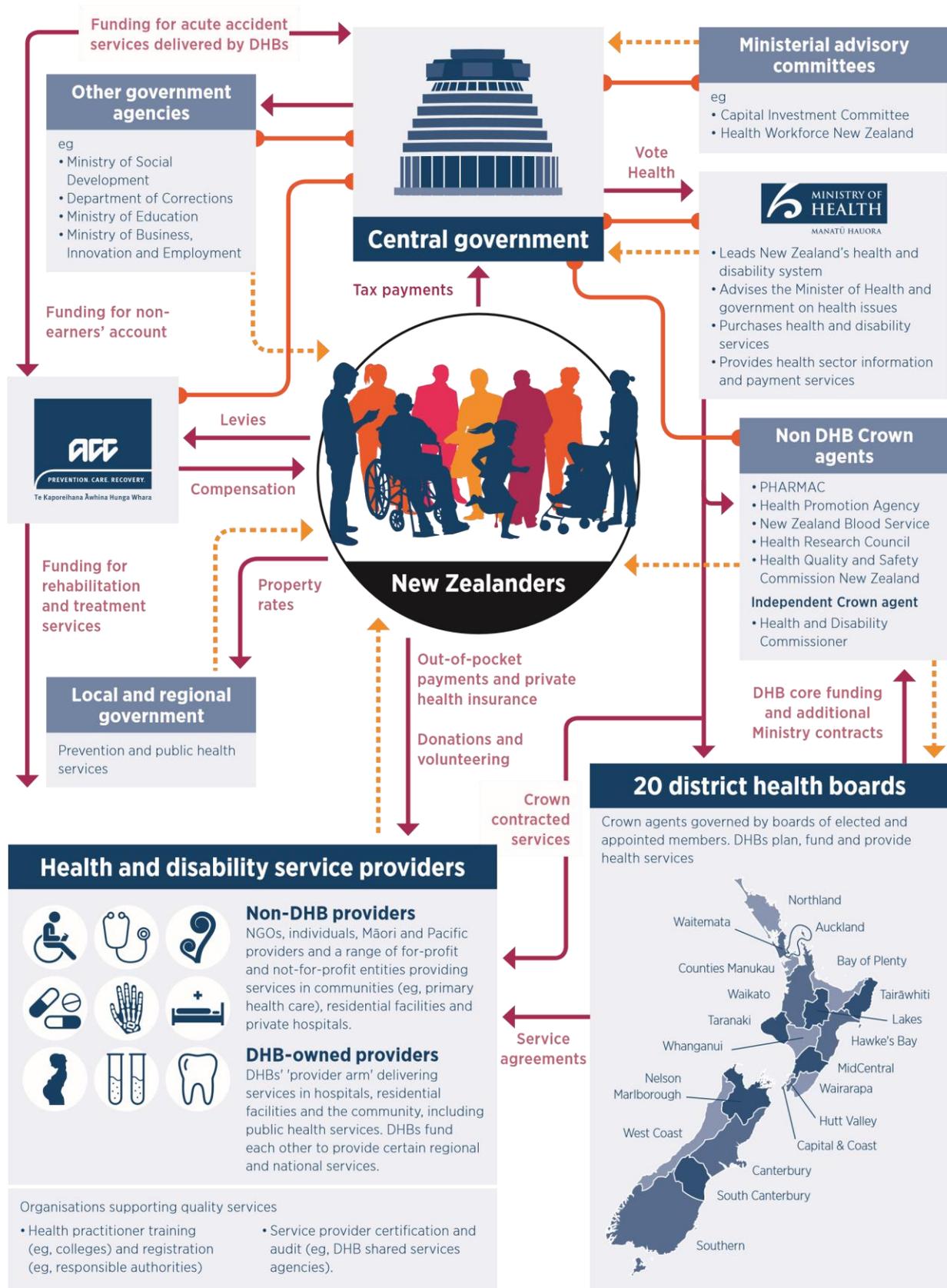
The Minister of Health (the Minister), with Cabinet and the Government, develops policy for the health and disability sector and provides leadership. The Minister is principally supported and advised by the Ministry of Health (the Ministry), and ministerial advisory committees.

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

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

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

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



## Statutory framework

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

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

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

### **Health Act 1956**

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

### **Crown Entities Act 2004**

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

## Funding the health and disability system

The health and disability system's funding comes mainly from Vote Health, which is administered by the Ministry. For 2017/18 this totals \$16.773 billion, the Vote having grown from \$12.240 billion in 2008/09.

### **Vote Health**

We invest in health because it is an important driver of economic and social prosperity of our society. Socially, better health is central to human happiness and well-being (physical, social, psychological and spiritual). If New Zealanders are healthy, they are more able to be autonomous and live the lives they want. This can extend to family and whānau. Healthy populations live longer and are more productive. Better health outcomes for the New Zealand population contribute to a more prosperous New Zealand for all.

The health and disability system's funding comes mainly from Vote Health, which was just over \$16.773 billion in 2017/18. **Appendix 2** show the components of Vote Health operating expenditure (excluding capital) and Ministry-managed non-departmental operating expenditure. Other significant funding sources include the Accident Compensation Corporation, other government agencies, local government, and private sources such as insurance and out-of-pocket payments.

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

## **Four Year Plan**

The Four Year Plan supports the longer term future direction described by the New Zealand Health Strategy. It is prepared by the Ministry, as stewards of the system, but is written from the perspective of the whole system, operating as one team to support all New Zealanders.

The Treasury and State Services Commission require departments to develop a Four Year Plan each year.

The Four Year Plan provides a snap-shot in time of our strategic and medium-term planning. It outlines how the New Zealand health and disability system will continue to meet the health needs of New Zealanders and deliver services that matter to people over the next four years. It provides insight into how we are addressing the following core questions:

- What are our strategic objectives and who are we helping (why do we exist)?
- What interventions (outputs, services, funding, asset provision and regulation) do we plan to deliver over the next four years to achieve our strategic objectives?
- How will we organise and manage our people and other resources (finances, information technology, assets, etc) to deliver these interventions?

## **Budget**

Four Year Plans provide central agencies with a 'state of play', indicating the current pressures and commitments facing the Government. These, along with the Government's intentions, support Budget decision-making and funding allocations.

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

## 2 Minister of Health

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

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

### Setting the strategic direction

#### System strategies

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

**Table 1: Strategies relating to the health and disability system**

New Zealand Health Strategy	The Minister must determine a strategy for health services: the New Zealand Health Strategy (under the New Zealand Public Health and Disability Act). The Minister must report each year on progress in implementing the Strategy. If the Strategy is reviewed, the Act requires consultation with appropriate organisations and individuals.
New Zealand Disability Strategy	The Minister for Disability Issues must determine a strategy for disability services: the New Zealand Disability Strategy (under the New Zealand Public Health and Disability Act). This Minister must report each year on progress in implementing the Strategy. If the Strategy is reviewed, the Act requires consultation with appropriate organisations and individuals.
He Korowai Oranga: Māori Health Strategy	He Korowai Oranga: Māori Health Strategy sets the overarching framework to guide the Government and the health and disability sector to achieve the best health outcomes for Māori. He Korowai Oranga means 'the cloak of wellness'. The Strategy was refreshed in June 2014, expanding the aim of He Korowai Oranga from whānau ora to pae ora – healthy futures.
Primary Health Care Strategy	The Primary Health Care Strategy was developed in 2001 to provide a clear direction for the future development of primary health care in New Zealand. Although now somewhat dated, it remains a useful document that outlines the specific contributions primary health care makes to improving health outcomes.
Healthy Ageing Strategy	The Healthy Ageing Strategy was published in 2016 and presents the strategic direction for change and a set of actions to improve the health of older people, into and throughout their later years. The strategy refreshes and replaces the Health of Older People strategy 2002 and aligned it with the New Zealand Health Strategy
'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018	'Ala Mo'ui has been developed to facilitate the delivery of high-quality health services that meet the needs of Pacific peoples. It sets out the strategic direction to address health needs of Pacific peoples and stipulates actions, which will be delivered from 2014 to 2018. This edition builds on the successes of the former plan from 2010-2014. The Ministry publishes reports on implementation progress periodically.
Other strategies in the health sector	There are a number of additional health strategies that guide specific areas of work in the health sector (eg, Cancer Control Strategy, Suicide Prevention Strategy, etc).

## Ministry of Health

The Minister is also responsible for the strategic direction of the Ministry. This is set using the following documents, including the Statement of Strategic Intent. The Minister approves the Ministry's Statement of Strategic Intent. In signing this document, the Minister confirms he or she is satisfied that the information on the Ministry's strategic directions is consistent with the priorities and performance expectations of the Government.

## Ensuring a high performing system

The health system relies on DHBs and other health Crown entities, the monitoring department (the Ministry), and the Minister working well together to ensure the delivery of health and disability services to New Zealanders.

Beyond setting the system's strategic direction, the Minister is responsible for the performance of DHBs and other health Crown entities (see **Chapter 5** and **Chapter 6**). The Ministry is responsible for monitoring these entities on behalf of the Minister, and for providing regular advice to the Minister on their performance. DHBs and other health Crown entities are accountable to government through the Minister.

The Minister has a range of ways to discharge these responsibilities:

### 1. **Setting Crown entities' strategic direction and annual performance requirements:**

The Minister is able to participate in setting the annual performance expectations of the Crown entity through the annual Statement of Performance Expectations. This lays out the information that the entity needs to provide to Parliament each year. The Minister can also engage regularly on performance expectations through, for example, talking to Chairs, meeting Boards, or issuing annual Letters of Expectations.

The Crown entity's Statement of Intent sets out the strategic objectives the entity intends to achieve or contribute to. The Minister can require amendments or a new Statement of Intent. The Minister may also adjust Crown funding such as appropriations, fees, and levies, subject to Cabinet consideration.

If desired, and depending on the nature of the specific Crown entity and its governing Act, the Minister may be able to give a direction on government policy. They can also recommend that a whole of government direction be given by the Ministers of State Services and Finance jointly to support whole of government approaches.

### 2. **Monitoring strategic direction and results**

Active monitoring of a health Crown entity's performance is important in ensuring that the contributions of the entity are aligned with the government's intentions and the contributions of other contributors in the health system. It will give early warning of any issues that need resolving. This may be assisted by having a no surprises policy in place.

The Minister can request information on performance and operations at any time, review performance and operations at any time, and ask the State Services Commissioner to act on issues (as per the State Sector Act 1988). To assist, the Minister can appoint a monitor for Crown entities (the Ministry currently monitors health Crown entities for the Minister).

### 3. **Board appointments, remuneration and removals**

The Minister recommends appointments and reappointments to the Boards of health Crown entities (including the Chair). How this works depends on the specific type of Crown entity, nonetheless the Minister is central to these appointments. It is useful for the Minister to provide a clear appointment letter stating what is expected from each appointee.

For Crown agents (including DHBs) the Minister sets the terms and conditions of appointment such as remuneration, and can set expectations around induction. The Minister is also central to the removal of Board members, and for DHBs, can appoint Crown monitors to the Board or replace the Board with a Commissioner.

## Other key roles under legislation

### **Health emergencies**

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

### **Health inquiries**

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

### **Responsibilities under mental health legislation**

The Mental Health (Compulsory Assessment and Treatment) Act 1992 allows for the compulsory assessment and treatment of people with a mental disorder who pose a serious danger to themselves or others, or have a seriously diminished capacity to take care of themselves.

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

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

# 3 Ministry of Health

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

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

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

## Purpose and role

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

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

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

## Leadership

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

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

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

## Advising the Government

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

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

### *Using data and analytics to guide investment*

Improving outcomes for New Zealanders spans agency boundaries. Interventions delivered by one agency will often have shared benefits well beyond that single agency's scope of influence. The Ministry is working in collaboration with other social sector agencies (including the Ministry of Social Development, Ministry of Vulnerable Children Oranga Tamariki, Ministry of Education) to build an understanding of people's needs through data and analytics, compare effectiveness of interventions, and prioritise investment in areas of greatest importance, for interventions with proven effectiveness.

All outcomes, analysis and service design are focused on understanding the needs of people requiring public services and the impact those services have on peoples' lives. An overview of this approach is shown in **Figure 2**.

*Figure 2: Using data and analytics to guide investment*



The Ministry is initially focussing on using this approach to guide investment decisions in the health sector in two ways:

- Applying investment principles to four priority health areas (mental health, disability, vulnerable children and primary health care). These principles are using data and analytics as one way to measure people's needs, systematically measuring the impact of health services on outcomes to understand what works for who, considering the relationship between health and other social outcomes, and intervening early in the life course. The Ministry has completed initial population analysis into a number of priority areas, including mental health, a cohort of people who self-harmed or died by suicide, primary health care, at-risk children and Māori women who smoke

- Building our understanding of value performance and effectiveness of health services through a prototype statistical model for Value Health. Specifically, we will trial using a statistical model to estimate the return we get from investment in health, measured by avoidance of health loss. We will then look at how this return differs across different population groups, and how different service scenarios affect the value of investment. As the model develops other social sector outcomes will be incorporated.

## Buying health and disability services

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

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

## Information and payments

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

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

## Statutory positions

### Director-General of Health

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

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

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

### **Director of Mental Health**

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

The Director's functions and powers under the Act allow the Ministry to provide guidance to mental health services, supporting the strategic direction provided in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* and a recovery-based approach to mental health. The Deputy Director of Mental Health is required to perform such duties as the Director may require. The Deputy Director is also the Ministry's Senior Advisor, Mental Health.

### **Director of Public Health**

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

### **Chief Financial Officer**

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

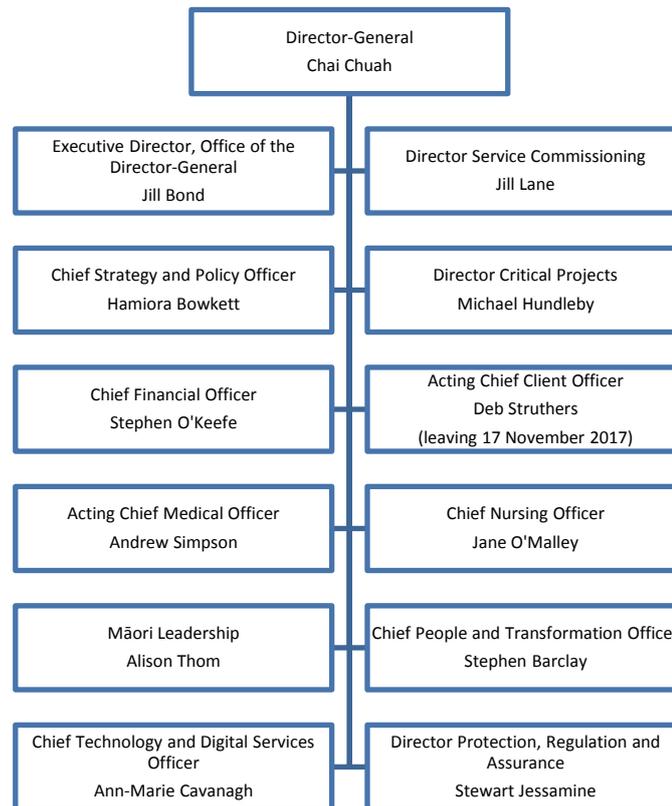
## **Executive Leadership Team**

Our Executive Leadership Team (see **Figure 3**) focuses on strategic management, corporate governance and organisational performance. It supports the Director-General of Health by:

- setting our strategic direction and priorities within the context of the Government's policy objectives for the health and disability system
- ensuring that we deliver on our strategies and goals by allocating resources, including purchasing health and disability services, performance monitoring organisations and accounting for the use of publicly funded resources

- ensuring that we have the capacity and capability to meet the Government’s objectives, including by having the people, information, structures, relationships, resources, culture and leadership to fulfil Government direction in the medium and long term
- supporting the Director-General’s financial and operational delegations by providing advice on key matters of health and disability public policy and implementation.

Figure 3: The Ministry of Health's Executive Leadership Team



## Clinical leadership roles within the Ministry

The Ministry employs health practitioners from a variety of backgrounds in a range of clinical leadership roles. These staff provide clinical expertise and sector leadership, and manage clinical areas of the Ministry’s work programme. The Ministry’s clinical leadership is jointly led by the Chief Medical Officer and the Chief Nursing Officer.

### Chief Medical Officer

The acting Chief Medical Officer is Dr Andrew Simpson. The Chief Medical Officer provides support and advice on clinical matters to the Director-General and other key stakeholders, clinical leadership and direction, and expert input into health services planning.

### Chief Nursing Officer

The Chief Nursing Officer, Dr Jane O’Malley, provides expert advice on nursing to government, provides professional leadership to the nursing profession, and ensures an effective New Zealand contribution to nursing and health policy in international forums (eg, the World Health Organization) and a close association with Australian colleagues (through the Australian and New Zealand Council of Chief Nurses).

# 4 Ministerial advisory committees

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

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

## Capital Investment Committee

The Chair of the Capital Investment Committee is Evan Davies, Managing Director, Todd Property. The Capital Investment Committee provides advice to the Ministers of Health and Finance and the Ministry on matters relating to capital investment and infrastructure in the public health sector in line with the Government's service planning direction. This includes working with DHBs to review their business case proposals, prioritisation of capital investment and delivery of a National Asset Management Plan, and any other matters that the Minister may refer to it.

## Digital Advisory Board

The Chair of the Digital Advisory Board is Michael Rillstone, Managing Director, RillstoneWells. The Digital Advisory Board was established in 2016. It recognises the key role of digital technology as an enabler in delivering better health care to New Zealanders.

The role of the Digital Advisory Board is to:

- link with the other advisory boards and health sector governance and advisory entities to share a common narrative of the digital, physical and biological technology future
- advise on specific digital initiatives (in the context of the overall portfolio of investment) to align them with a person-centred digital future
- encourage and promote disruptive innovation in support of the New Zealand Health Strategy
- support the Director-General of Health to deliver a digitally enabled health and disability system as set out in the New Zealand Health Strategy and its five themes: people powered, closer to home, value and high performance, one team and smart system.

## Health Workforce New Zealand

The Chair of Health Workforce New Zealand is Professor Des Gorman. Health Workforce New Zealand is an advisory board established under section 11 of the New Zealand Public Health and Disability Act 2000. It advises the Minister and the Director-General of Health on the performance of the Ministry's Health Workforce unit, which aims to ensure that the New Zealand public has a health care workforce fit to meet its needs. Its work includes supporting and funding workforce development initiatives, financial support for postgraduate programmes and schemes to target hard-to-staff communities and specialties.

## Other ministerial advisory committees

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

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

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

# 5 Crown entities

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

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

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

There are 26 statutory entities in the Health portfolio, as summarised in **Table 2**.

**Table 2: Health portfolio Crown entities, office holders and chief executives**

Type	Entity	Chair	Deputy chair	Chief executive
<i>Crown agents</i>	District Health Boards (20)	This information is provided in <b>Table 9</b>		
Crown agents must give effect to policy that relates to the entity’s functions and objectives if directed by Minister. The Minister appoints board members and has the power to remove a board member from office at his or her discretion.	Health Promotion Agency	Dr Lee Mathias	Dr Monique Faleafa	Clive Nelson
	Health Quality & Safety Commission	Prof Alan Merry	Shelley Frost	Dr Janice Wilson
	Health Research Council of New Zealand	Dr Lester Levy	Prof Andrew Mercer	Dr Kathryn McPherson
	New Zealand Blood Service	David Chamberlain	Ian Ward	Sam Cliffe
	Pharmaceutical Management Agency (PHARMAC)	Stuart McLauchlan	(Vacant)	Steffan Crausaz
<i>Independent Crown entity</i>	Health and Disability Commissioner	Anthony Hill (Commissioner)	Meenal Duggal (Deputy Commissioner, Complaints Resolution) Kevin Allan (Mental Health Commissioner) Rose Wall (Deputy Commissioner, Disability)	N/A

Type	Entity	Chair	Deputy chair	Chief executive
<i>Autonomous Crown entity</i>	There are no autonomous Crown entities in the health portfolio.			
Autonomous Crown entities must have regard to policy that relates to the entity's functions and objectives if directed by Minister. The Minister appoints board members and may remove a board member from office with a justifiable reason.	Previously, the Alcohol Advisory Council of New Zealand fell within this classification. Alcohol Advisory Council of New Zealand and the Health Sponsorship Council were merged in 2012 to create the Health Promotion Agency (a Crown agent).			

## Board appointments

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

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

## Accountability and performance

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

### Annual Letter of Expectations

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

### Enduring Letter of Expectations

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

### Statement of Intent and Statement of Performance Expectations

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

## Output Agreement

This is the principal relationship agreement between the Minister and each entity. It contains entity-specific agreed performance targets, as set out in the Statement of Performance Expectations. DHBs' Output Agreements are known as Crown Funding Agreements.

## Annual Report

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

## Directions

### Policy directions

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

### Whole of government directions

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

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

### DHB-specific directions

The Minister has additional direction-giving powers under the New Zealand Public Health and Disability Act 2000 in respect of DHBs (see page 30).

## Crown agents

### District health boards

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

## Health Promotion Agency

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

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

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

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

Measure	Actual (\$m)	Budget (\$m)		
	2016/17	2017/18	2018/19	2019/20
Income	33.394	27.708	27.708	27.708
Expenditure	33.158	27.708	27.708	27.708
Surplus/(deficit)	0.336	0.000	0.000	0.000
Equity	3.539	2.658	2.658	2.658

## Health Quality & Safety Commission

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

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

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

Measure	Actual (\$m)	Forecast (\$m)		
	2016/17	2017/18	2018/19	2019/20
Income	16.797	16.097	15.197	14.776
Expenditure	16.904	16.187	15.287	14.776
Surplus/(deficit)	(0.112)	(0.090)	0.000	0.000
Equity	1.058	1.120	1.120	1.120

## Health Research Council of New Zealand

The Health Research Council of New Zealand is the principal government funder of health research. It funds health research in four broad areas:

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

The Health Research Council of New Zealand was established under the Health Research Council Act 1990 and is responsible to the Minister. It is largely funded from Vote Science and Innovation. A Memorandum of Understanding governs the relationship; the Minister and Minister of Science and Innovation work closely together to provide direction and set expectations.

*Table 5: Health Research Council financial forecast*

Measure	Actual (\$m)	Forecast (\$m)		
	2016/17	2017/18	2018/19	2019/20
Income	94.522	102.526	110.570	127.602
Expenditure	95.750	105.964	113.764	131.314
Surplus/(deficit)	1.170	(3.438)	(3.164)	(3.712)
Equity	14.618	9.713	6.647	3.032

## New Zealand Blood Service

The New Zealand Blood Service ensures the supply of safe blood products. It provides an integrated national blood transfusion process, from the collection of blood from volunteer donors to the provision of blood products within the hospital environment. The New Zealand Blood Service is funded through the sale of blood products to DHBs.

*Table 6: New Zealand Blood Service financial forecast*

Measure	Actual (\$m)	Forecast (\$m)		
	2016/17	2017/18	2018/19	2019/20
Income	114.654	118.446	122.866	127.869
Expenditure	114.799	120.301	123.761	127.854
Surplus/(deficit)	(0.145)	(1.855)	(0.875)	(0.015)
Equity	39.399	36.497	35.622	35.637

## Pharmaceutical Management Agency

The Pharmaceutical Management Agency (PHARMAC) has a legislative objective to secure for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided. PHARMAC manages the Pharmaceutical Schedule which applies consistently across New Zealand, and decides which medicines, therapeutic medical devices and related products are publicly funded, who can prescribe them and who can access them.

PHARMAC manages a fixed budget, called the Combined Pharmaceutical Budget, which is determined on an annual basis by the Minister after receiving advice from PHARMAC and DHBs. The Combined Pharmaceutical Budget value for 2016/17 is \$849.6 million.

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

PHARMAC also has a large and expanding role in DHB hospitals. It makes decision on which medicines may be used in hospitals, and negotiates national contracts for hospital medical devices. It is working towards managing fixed budgets for hospital medicines and medical devices, which is a vital component of its business model.

PHARMAC's main roles include:

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

*Table 7: PHARMAC financial forecast*

Measure	Actual (\$m)	Forecast (\$m)		
	2016/17	2017/18	2018/19	2019/20
Income	24.176	27.605	27.206	26.663
Expenditure	23.281	26.105	27.606	27.063
Surplus/(deficit)	0.894	1.500	(0.400)	(0.400)
Equity	35.967	36.953	36.553	36.153

## Independent Crown entity

### Health and Disability Commissioner

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

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

*Table 8: Health and Disability Commissioner financial forecast*

Measure	Actual (\$m)	Forecast (\$m)		
	2016/17	2017/18	2018/19	2019/20
Income	12.396	13.435	13.435	13.435
Expenditure	12.510	13.435	13.435	13.435
Surplus/(deficit)	(0.116)	0	0	0
Equity	1.303	1.328	1.328	1.328

## Crown-owned company

### NZ Health Partnerships

Owned, led and supported by New Zealand's 20 DHBs, NZ Health Partnerships was established as a Crown subsidiary on 1 July 2015. Each DHB has an equal stake in NZ Health Partnerships and equal voting rights. The DHBs interact with NZ Health Partnerships as co-creators, shareholders and customers.

NZ Health Partnership's initiatives are focused on creating financial efficiencies for DHBs to help them meet the increasing demands placed on the health and disability system – particularly from an aging population and the rising cost of new clinical equipment. Its focus is on administrative, support and procurement activities that have direct and indirect clinical benefits.

In addition to their shareholders, NZ Health Partnerships works collaboratively with a number of public and private sector organisations to ensure the successful delivery of programmes and services.

# 6 District health boards

There are currently 20 DHBs in New Zealand (see **Figure 4** and **Table 9**). DHBs are responsible for implementing the health policies of the Government, and for providing or funding the provision of health services in their districts. DHBs fund primary health organisations (PHOs) to provide essential primary health care services to their populations. Public hospitals are owned and funded by DHBs (see **Appendix 4** for a list of public hospitals in New Zealand).

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

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

Other DHB objectives include:

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

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

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

The four regions are:

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

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

Figure 4: District Health Board boundaries



**Table 9: DHB office holders, chief executives, populations and 2017/18 funding**

DHB	Chair (elected/appointed)	Deputy chair (elected/appointed)	Chief executive	Population	2017/18 funding
Northland	Sally Macauley (elected)	Sue Brown (appointed)	Dr Nick Chamberlain	175,220	\$561.9 million
Waitematā	Dr Lester Levy (appointed)	Kylie Clegg (appointed)	Dr Dale Bramley	615,340	\$1460.3 million
Auckland	Dr Lester Levy (appointed)	Dr James Le Fevre (appointed)	Ailsa Claire	530,460	\$1248.9 million
Counties Manukau	Dr Lester Levy (appointed)	Rabin Rabindran (appointed)	Gloria Johnson (acting)	551,390	\$1368.7 million
Waikato	Bob Simcock (appointed)	Sally Webb (appointed)	Derek Wright (interim)	411,520	\$1136.4 million
Lakes	Deryck Shaw (appointed)	Lyll Thurston (elected)	Ron Dunham	108,320	\$312.8 million
Bay of Plenty	Sally Webb (appointed)	Ron Scott (elected)	Helen Mason	233,590	\$691.9 million
Tairāwhiti	David Scott (appointed)	Geoff Milner (appointed)	Jim Green	48,430	\$160.2 million
Taranaki	Pauline Lockett (appointed)	Neil Volzke (appointed)	Rosemary Clements	118,965	\$334.6 million
Hawke's Bay	Kevin Atkinson (elected)	Ngahiwi Tomoana (appointed)	Dr Kevin Snee	163,580	\$480.9 million
Whanganui	Dot McKinnon (appointed)	Stuart Hylton (elected)	Russell Simpson	63,270	\$217.6 million
MidCentral	Dot McKinnon (appointed)	Brendan Duffy (appointed)	Kathryn Cook	175,880	\$492.5 million
Hutt Valley	Andrew Blair (appointed)	Wayne Guppy (elected)	Dr Ashley Bloomfield	147,520	\$383.6 million
Capital & Coast	Andrew Blair (appointed)	Fran Wilde (elected)	Debbie Chin (leaving)	311,670	\$733.8 million
Wairarapa	Sir Paul Collins (appointed)	Leanne Southey (elected)	Adri Isbister	44,135	\$134.8 million
Nelson Marlborough	Jenny Black (elected)	Alan Hinton (appointed)	Dr Peter Bramley	148,370	\$416.9 million
West Coast	Jenny Black (appointed)	Christopher Mackenzie (appointed)	David Meates	32,600	\$127.8 million
Canterbury	Dr John Wood (appointed)	Sir Mark Solomon (appointed)	David Meates	558,830	\$1369.5 million
South Canterbury	Ron Luxton (elected)	Paul Annear (elected)	Nigel Trainor	60,040	\$176.4 million
Southern	Kathy Grant (Commissioner – appointed by the Minister)	Graham Crombie and Richard Thomson (Deputy Commissioners – appointed by the Commissioner)	Chris Fleming	324,090	\$844.2 million

## Shared services agencies and subsidiaries

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

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

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

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

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

## Board appointments

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

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

At present, a number of DHB board positions are held jointly (see **Table 9**). Such cross-appointments are made to foster greater collaboration between DHBs. For example, in the Northern Region several Board members have been appointed across two of the four Northern Region DHB Boards; there is a single Chair across the three DHBs in Auckland (Auckland DHB, Waitematā DHB and Counties Manukau DHB).

The Minister may appoint a Crown Monitor or monitors to sit on a DHB's board if the Minister considers it desirable to do so to improve that DHB's performance. The Minister may also dismiss a DHB board and replace it with a commissioner if the Minister is seriously dissatisfied with that board's performance. A commissioner was appointed to Southern DHB in June 2015. Her term is due to end in 2019, to coincide with local body elections.

## Accountability

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

### **Government expectations**

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

#### *Annual Letter of Expectations*

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

#### *Enduring Letter of Expectations*

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

### **Planning documents**

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

#### *Annual Plan*

Each DHB agrees with the Minister on an Annual Plan. This plan sets out how the DHB delivers health services locally to meet Government priorities, with a focus on health equity, and how this can be provided in a financially responsible manner and in line with the DHB's role and functions. DHBs also previously produced Māori Health Plans each year to set out how the DHB planned to reduce health disparities between Māori and non-Māori. Māori Health Plans have been incorporated into DHB Annual Plans in 2017/18 and the focus on equity has been strengthened in these plans.

#### *Regional Service Plan*

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

## Accountability documents

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

### *Statement of Intent*

Each DHB is required to publish a Statement of Intent at least once every three years, setting out the high-level objectives and strategic focus for the next four financial years (eg, Statements of Intent published in the 2016/17 financial year also cover 2017/18, 2018/19 and 2019/20).

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

In those years that Statements of Intent are required, DHBs are encouraged to include their Statement of Intent as a component of the Annual Plan in order to reduce duplication of information. The Statement of Intent component can then be extracted from the Annual Plan for tabling in Parliament.

### *Statement of Performance Expectations*

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

The DHB board prepares the Statement of Performance Expectations, with comment from the Minister. Once the board signs it off, the Minister tables the Statement of Performance Expectations in Parliament.

### *Crown Funding Agreement*

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

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

### *Operational Policy Framework*

The Operational Policy Framework is a set of business rules, policies and guideline principles that outline the operating functions of DHBs. The Operational Policy Framework is one of the schedules of the Crown Funding Agreement and is updated annually.

## Service Coverage Schedule

The Service Coverage Schedule sets out the national minimums for the range and nature of health services to be funded by DHBs. For some services the Service Coverage Schedule also covers subsidies and user charges, as well as specific quality and audit requirements. The Service Coverage Schedule is another schedule of the Crown Funding Agreement and is updated annually.

## Annual Report

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

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

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

## Quality Accounts

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

The accountability cycle timetable, showing how the various government expectations, planning documents and accountability documents fit together, is set out in **Table 10**.

**Table 10: Accountability cycle for DHBs**

1 February	Crown Funding Agreement variations signed by both parties (inclusion of new service schedules).
March/May	Drafts of the Annual Plan, with Statement of Intent (SOI), as required, and the Statement of Performance Expectations (SPE) and Regional Service Plan are provided to the Minister (via the Ministry). The Minister (via the Ministry) provides feedback.
1 May	Crown Funding Agreement variations signed by both parties (roll-overs of existing service schedules).
June	The final Annual Plan, with SOI, as required, the SPE and the Regional Service Plan are provided to the Minister for approval.
30 June	End of financial year.
As soon as practicable	as DHBs publish the Annual Plan with SOI, as relevant, and the SPE. The Minister presents the DHB SOI, as required, and the SPE to the House of Representatives. When the SOI falls due for tabling once every three years, the Minister can present the Annual Plan containing the component SOI and the SPE, or the SOI and SPE can be presented as stand-alone documents.
1 July	Crown Funding Agreement variations signed by both parties (inclusion of new service schedules).
1 October	Crown Funding Agreement variations signed by both parties (inclusion of new service schedules).

November	DHBs must produce an Annual Report following the end of the financial year. A final, board-approved Annual Report for the preceding financial year must be provided to the Minister no later than mid-November. This is also the last opportunity for DHB SOIs and SPEs for the current year to be tabled, if they have not been already.  Draft Letter of Expectations is prepared for the Minister.
December	DHBs publish their Quality Accounts on their website and submit these to the Health Quality & Safety Commission. DHBs may wish to publish their Quality Accounts as part of their Annual Report.  Minister's Letter of Expectations is sent to DHB chairs.

## Performance

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

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

### Financial performance

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

### Non-financial performance

#### *Health targets*

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

#### *Quarterly summaries*

Quarterly summary reports provide an overview of DHB performance against expectations. The report is presented using a consolidated dashboard approach, showing an at-a-glance snapshot of DHB performance across a range of key markers as at 30 September, 31 December, 31 March and 30 June. Performance measures previously associated with Māori Health Plans will be included in the quarterly summary reports from quarter one 2017/18.

## *District alliances*

District alliances are local partnerships between health providers, organisations and funders. All DHBs must be members of an alliance. Effective alliances are dependent on mature relationships at a local level.

Alliances provide a high trust forum for joint service development that reflects shared responsibility for a whole of system approach to performance and service provision. While initially only including DHBs and PHOs, alliance membership will broaden over time (eg, lead maternity carers, providers of ambulance services, Well Child / Tamariki Ora services, and youth health services) in order to successfully implement the System Level Measures.

## *System Level Measures*

System Level Measures, implemented from 1 July 2016, provide a framework for continuous quality improvement and system integration. System Level Measures have a focus on children, youth and vulnerable populations and enables integration to improve population health outcomes, reduce inequities and provide value for money. In order to be successful, implementation of System Level Measures require integration of all parts of the health and disability system.

All district alliances are now implementing their jointly developed 2017/18 System Level Measures Improvement Plans covering the following six measures:

- reduce Ambulatory Sensitive Hospitalisation rates per 100,000 for 0 – 4 year olds
- reduce acute hospital bed days per capita
- patient experience of care (inpatient and primary care surveys)
- reduce amenable mortality rates
- proportion of babies living in a smoke-free household at six weeks post birth
- youth health measure.

## DHB-specific directions

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

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

## Funding and services

DHBs exist within a funding environment where:

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

DHB funding (\$12.163 billion in 2016/17) is distributed using the population-based funding formula, which allocates funding based on the size and composition of each DHB’s population. This means the share of funding each DHB receives is largely determined by whether (and by how much) its population is growing or shrinking relative to others. Statistics New Zealand provides updated DHB populations annually for use in setting DHB funding shares.

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

The Service Coverage Schedule (a schedule to the Crown Funding Agreement) outlines the national minimum range and standard of health and disability services to be publicly funded, and DHBs are required to ensure their populations have access to all these services. DHBs may provide the services directly or contract with third parties. A DHB may also purchase certain specified services for their population from another DHB using a system known as ‘inter-district flows’. Where these services are provided by another DHB, a national agreed price is generally used or DHBs may agree on local arrangements between themselves. A nationwide service framework is in place to ensure an appropriate degree of national consistency as directed by the agreed policy settings for specific services.

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

## Employment relations

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

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

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

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

Under the New Zealand Public Health and Disability Act 2000, DHB chief executives must consult with the Director-General of Health before finalising the terms and conditions of a collective agreement. These obligations are explained further by specific Ministry guidelines, the Operational Policy Framework and the Government Expectations for Pay and Employment Conditions in the State Sector.

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

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

### **Health Sector Relationship Agreement**

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

# 7 Other office holders, organisations and networks

## Statutory officers

### **Public health statutory officers**

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

### **Mental health statutory officers**

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

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

### **Other statutory officers**

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

## Primary health organisations

DHBs fund PHOs to ensure the provision of essential primary health care services to those people who are enrolled with a GP. There are 31 PHOs (South Canterbury DHB acts as its own PHO, and is sometimes referred to as the 32<sup>nd</sup> PHO) which vary widely in size and structure. All PHOs are not-for-profit organisations.

A PHO provides primary health services either directly or through its provider members, primarily general practices. These services are designed to improve and maintain the health of the enrolled PHO

population, as well as having the responsibility for ensuring that services are provided in the community to restore people's health when they are unwell. The aim is to ensure GP services are better linked with other health services to ensure a seamless continuum of care.

## Accident Compensation Corporation

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

## National Ambulance Sector Office

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

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

## Non-government organisations

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

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

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

## Public health units

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

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

## Local authorities

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

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

## Clinical networks

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

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

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

The Major Trauma National Clinical Network provides clinical leadership and oversight to support a planned and consistent approach to the provision of major trauma services across New Zealand. The Network's Clinical Leader is Associate Professor Ian Civil.

Its work programme includes the establishment of, and reporting from, a National Major Trauma Registry and the establishment of nationally consistent clinical guidelines and pre-hospital destination policies. The aim of the Major Trauma National Clinical Network is to reduce preventable levels of mortality, complications and lifelong disability amongst people who sustain a major trauma injury. The Network is hosted by the Accident Compensation Corporation.

## **National Stroke Network**

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

## **New Zealand Cardiac Network**

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

## **National Cardiac Surgery Clinical Network**

The National Cardiac Surgery Clinical Network provides national leadership across cardiac surgery services to increase the volume of cardiac surgery operations, improve the geographical equity of cardiac surgery provision, enhance the effectiveness of clinical prioritisation, and reduce the number of patients waiting for surgery. The National Cardiac Surgery Clinical Network is chaired by Mr Harsh Singh.

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

The Adolescent and Young Adult Cancer Network Aotearoa is focused on improving cancer outcomes for adolescents and young adults. The Clinical Lead for the Adolescent and Young Adult Cancer Network Aotearoa is Heidi Watson. The Network supports all providers of cancer services for adolescents and young adults and has developed relevant standards of care.

## **National Child Cancer Network**

The National Child Cancer Network provides advice, recommendations and action plans on specific areas of service delivery (eg, fertility preservation) and shares information, knowledge and best practice across the country. The National Child Cancer Network's Chair is Dr Scott Macfarlane.

## **National Child and Youth Clinical Network**

The National Child and Youth Clinical Network acts as an oversight network for paediatric specialist networks. The Chair of the National Child and Youth Clinical Network is Dr Richard Aickin. The National Child and Youth Clinical Network works in partnership with key stakeholders to strengthen clinical leadership and engagement, support improved local, regional and national service and capacity planning, and improve system performance in child and youth health.

## **Regional cancer networks**

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

- The Northern Cancer Network is led by Dr Richard Sullivan.
- The Midland Cancer Network is led by Dr Humphrey Pullon.
- The Central Cancer Network is led by Dr Bart Baker.
- The Southern Cancer Network is led by Dr Shaun Costello.

# 8 International links

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

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

## International contacts

### World Health Organization

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

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

Ministers of Health are invited to attend a range of health forums across international organisations, including the World Health Assembly (the annual World Health Organization health forum, held each May in Geneva, Switzerland). The World Health Assembly is the annual overarching decision making body of the World Health Organization. It is attended by delegations from up to 194 Member States.

### The Commonwealth

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

### Australia

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

Benefits of New Zealand's involvement in Council of Australian Governments Health Council include the opportunity to network among peers; to observe health system development and reform in our nearest

and biggest neighbour; and to learn from these opportunities, provide a New Zealand position, and influence decisions in areas of mutual interest.

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

### **Pacific links**

Pacific Health Ministers meet every two years to consider regional initiatives and collaborate on existing or emerging health issues. The biennial meeting is hosted by the World Health Organization and the Pacific Community. New Zealand and Australia are invited as observers to the meetings. The latest meeting was held in August 2017 in a Rarotonga, Cook Islands.

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

## **International conventions**

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

### **World Health Organization Framework Convention on Tobacco Control**

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

### **International Health Regulations**

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

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

## United Nations Sustainable Development Goals

In September 2015, New Zealand signed up to the set of 17 United Nations Sustainable Development Goals and 169 targets. The Sustainable Development Goals establish a universal agenda for action until 2030 to achieve sustainable development within countries and globally (2030 Agenda for Sustainable Development).

New Zealand is expected to formally provide an all-of-government report on progress with the Sustainable Development Goals twice over the 15 year timeframe to the High Level Political Forum on Sustainable Development.

# Appendix 1: Legal and regulatory framework

## Legislation the Ministry administers

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

<b>Alcoholism and Drug Addiction Act 1966</b>	Provides for the care and treatment of people with alcohol and drug addictions.
<b>Burial and Cremation Act 1964</b>	Outlines the law relating to the burial and cremation of the dead.
<b>Cancer Registry Act 1993</b>	Provides for the compilation of a statistical record of the incidence of cancer in its various forms, as a basis for better direction of programmes for research and for cancer prevention.
<b>Care and Support Workers (Pay Equity) Settlement Act 2017</b>	This settlement addresses a historic undervaluing of care and support workers in New Zealand's aged and disability residential care, and home and community support services.
<b>Children's Health Camps Board Dissolution Act 1999</b>	Dissolves the Children's Health Camps Board, transfers its assets to a foundation incorporated under Part 2 of the Charitable Trusts Act 1957 and provides for incidental matters.
<b>Compensation for Live Organ Donors Act 2016</b>	Provides for compensation for lost income to be paid to live donors of organs.
<b>Disabled Persons Community Welfare Act 1975, Part 2A</b>	Sets out the right of people in residential care to a review of the adequacy of any disability services, and whether or not a person's disability service needs are appropriately met by the residential care received.
<b>Epidemic Preparedness Act 2006</b>	Provides statutory power for government agencies to prevent and respond to the outbreak of epidemics in New Zealand, and to respond to particular possible consequences of epidemics (whether occurring in New Zealand or overseas). This Act also aims to ensure that certain activities can continue during an epidemic in New Zealand, and to enable the relaxation of some statutory requirements that might not be capable of being complied with, or complied with fully, during an epidemic.
<b>Health Act 1956</b>	Sets out the roles and responsibilities of individuals to safeguard public health, including the Minister, the Director of Public Health and designated officers for public health. It contains provisions for environmental health, infectious diseases, health emergencies and the National Cervical Screening Programme.
<b>Health and Disability Commissioner Act 1994</b>	Aims to promote and protect the rights of health consumers and disability service consumers to secure fair, simple, speedy and efficient resolution of complaints. It provides for the appointment of a Health and Disability Commissioner to investigate complaints, and defines the Commissioner's functions and powers. It also provides for the establishment of a Health and Disability Services Consumer Advocacy Service, and for the promulgation of a Code of Health and Disability Services Consumers' Rights.
<b>Health and Disability Services (Safety) Act 2001</b>	Promotes the safe provision of health and disability services to the public, and establishes consistent and reasonable standards of service for providers.
<b>Health Benefits (Reciprocity with Australia) Act 1999</b>	Provides for reciprocity with Australia in relation to pharmaceutical, hospital and maternity benefits.
<b>Health Benefits (Reciprocity with the United Kingdom) Act 1982</b>	Provides for reciprocity with the United Kingdom in relation to medical, hospital and related benefits.

<b>Health Practitioners Assurance Act 2003</b>	<b>Competence</b>	Aims to ensure health practitioners are competent and fit to practise their professions. It provides for: <ul style="list-style-type: none"> <li>(a) a consistent accountability regime for all health professions</li> <li>(b) the determination of the scope of practice within which each health practitioner is competent</li> <li>(c) systems to ensure that no health practitioner practises outside his or her scope of practice</li> <li>(d) power to restrict specified activities to particular classes of health practitioner</li> <li>(e) certain protections for health practitioners who take part in protected quality assurance activities.</li> </ul>
<b>Health Research Council Act 1990</b>		Defines the functions and powers of the Health Research Council of New Zealand, a Crown entity responsible for managing government's investment in health research.
<b>Health Sector (Transfers) Act 1993</b>		Governs the sale or transfer of assets, liabilities or functions from DHBs and certain health Crown entities to the Crown or other specified bodies.
<b>Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016</b>		Provides for payment of wages to home and community support workers for travel between clients.
<b>Human Assisted Reproductive Technology Act 2004 (in conjunction with the Ministry of Justice)</b>		Governs assisted reproductive technology, including by: providing a framework for the regulation and performance of assisted reproductive procedures; prohibiting certain procedures, types of research and transactions; and establishing an information keeping regime for people born from donated embryos or cells to find out about their genetic origins.
<b>Human Tissue Act 2008</b>		Governs the collection and use of human tissue to ensure that this is done in an appropriate way, without endangering the health and safety of members of the public, and that it does not involve payment.
<b>Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003</b>		Provides for the compulsory care and rehabilitation of individuals with an intellectual disability who have been charged with, or convicted of, an imprisonable offence.
<b>Medicines Act 1981</b>		Covers the law relating to the manufacture, sale and supply of medicines, medical devices and related products.
<b>Mental Health (Compulsory Assessment and Treatment) Act 1992</b>		Defines the circumstances and conditions under which people may be subjected to compulsory psychiatric assessment and treatment. It defines and protects the rights of such people, and generally defines the law relating to the assessment and treatment of people suffering from mental disorders.
<b>Mental Hospitals Reserves Act 1908</b>		Authorises the disposal by lease or otherwise of certain Mental Hospitals Reserves.
<b>Misuse of Drugs Act 1975</b>		Aims to prevent the misuse of drugs.
<b>New Zealand Council for Postgraduate Medical Education Act Repeal Act 1990</b>		Dissolves the New Zealand Council for Postgraduate Medical Education and repeals the New Zealand Council for Postgraduate Medical Education Act 1978.
<b>New Zealand Public Health and Disability Act 2000</b>		Establishes the structure underlying public sector funding and the organisation of health and disability services. It establishes DHBs and certain health Crown entities, and sets out the duties and roles of key participants, including the Minister and ministerial advisory committees.
<b>New Zealand Public Health and Disability (Southern DHB) Elections Act 2016</b>		Cancelled the 2016 triennial general election of the Southern DHB in order to provide, until the repeal date, for the continuation of the term of office of a commissioner for the Southern DHB.
<b>Psychoactive Substances Act 2013</b>		Regulates the importation, manufacture and supply of psychoactive substances in New Zealand to protect the health of, and minimise harm to, individuals who use psychoactive substances.
<b>Radiation Safety Act 2016</b>		Establishes a framework to protect the health and safety of people and protect the environment from the harmful effects of ionising radiation while allowing for the safe and beneficial use of ionising radiation. Enables New Zealand to meet international obligations relating to radiation and nuclear non-proliferation.

<b>Smoke-free Environments Act 1990</b>	Aims to: <ul style="list-style-type: none"> <li>(a) reduce the exposure of people who do not themselves smoke to any detrimental effect on their health caused by others' smoking</li> <li>(b) regulate the marketing, advertising and promotion of tobacco products, whether directly or through the sponsoring of other products, services or events</li> <li>(c) monitor and regulate the presence of harmful constituents in tobacco products and tobacco smoke.</li> </ul>
<b>Social Security (Long-term Residential Care) Amendment Act 2006</b>	Sets out the regime for determining liability in respect of the cost of providing long-term residential care.
<b>Substance Addiction (Compulsory Assessment and Treatment) Act 2017</b>	Enables people to receive compulsory treatment if they have a severe substance addiction and their capacity to make decisions about treatment for that addiction is severely impaired.

## Other regulatory roles and obligations

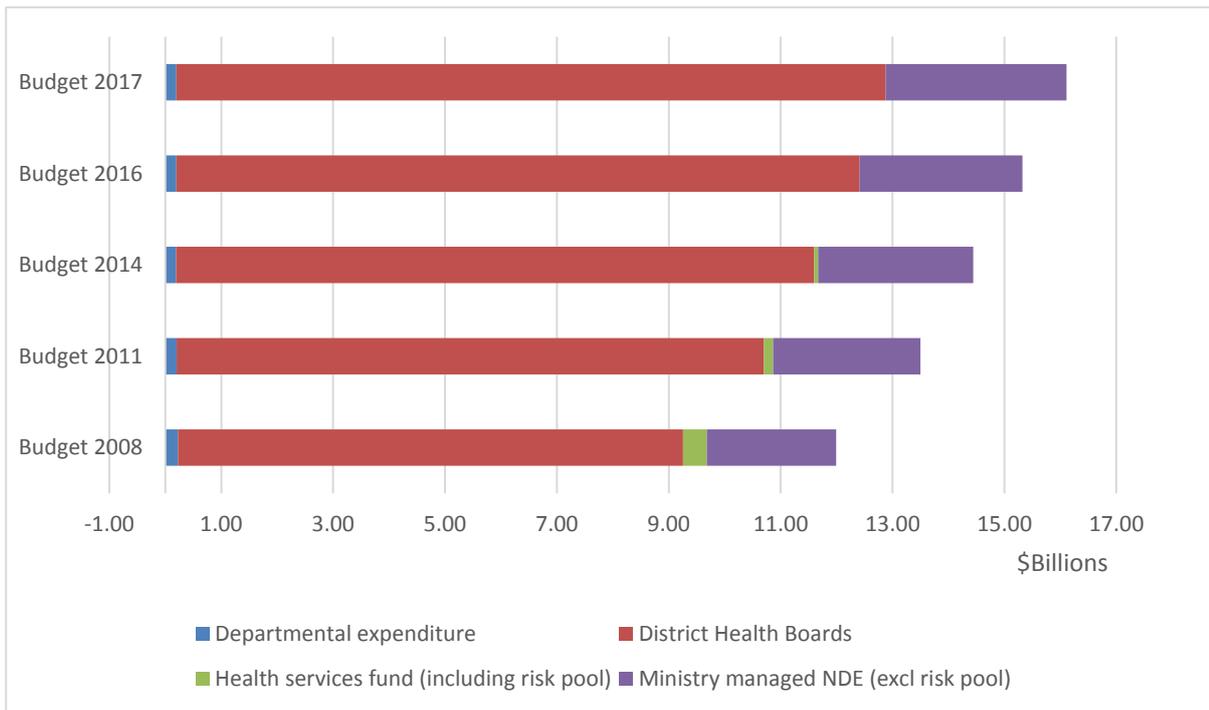
In addition to administering legislation, key personnel within the Ministry (such as the Directors of Public Health and Mental Health) have specific statutory powers and functions under various pieces of legislation.

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

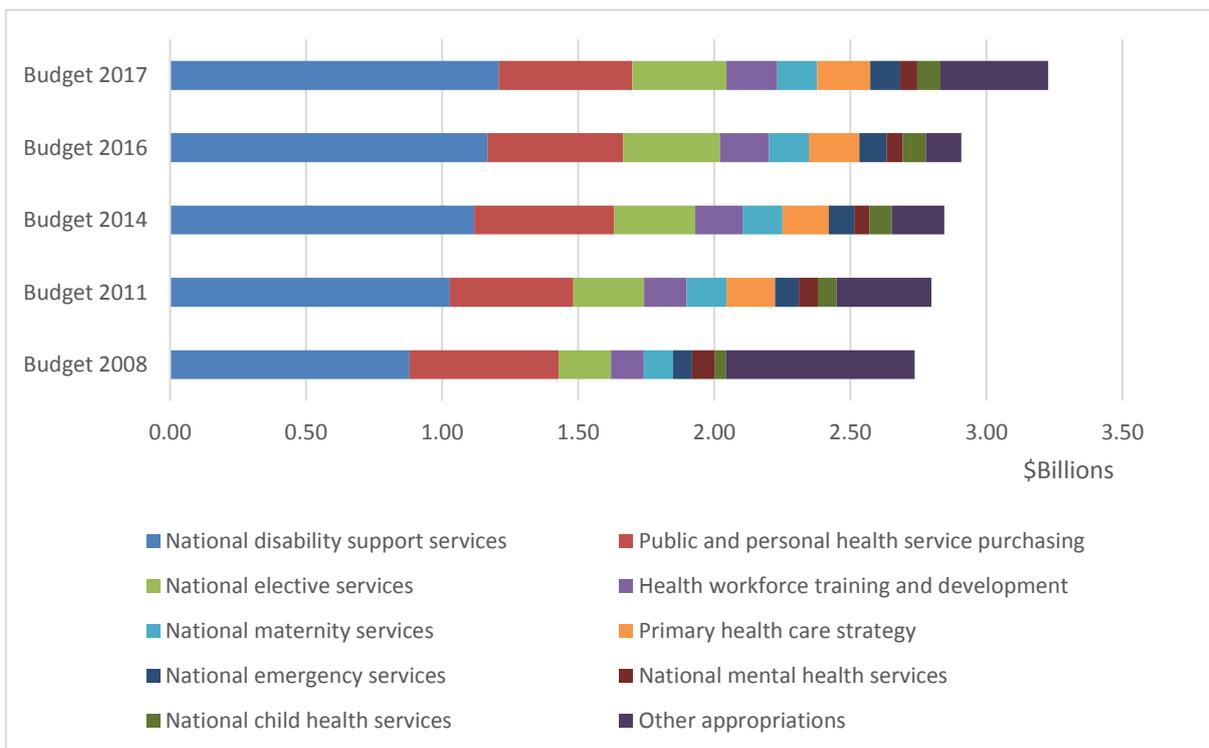
- Biosecurity Act 1993
- Civil Defence Emergency Management Act 2002
- Education Act 1989
- Food Act 1981
- Gambling Act 2003
- Hazardous Substances and New Organisms Act 1996
- Human Assisted Reproductive Technology Act 2004
- Litter Act 1979
- Local Government Act 2002
- Maritime Security Act 2004
- Prostitution Reform Act 2003
- Sale and Supply of Liquor Act 2012
- Social Security Act 1964
- Victims' Rights Act 2002
- Waste Minimisation Act 2008.

# Appendix 2: Vote Health

Components of Vote Health operating expenditure – excluding capital, \$billion



Components of Ministry-managed non-departmental operating expenditure, \$billion



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

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

## Health Act 1956

### **National Kaitiaki Group**

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

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

### **National Cervical Screening Programme review committee**

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

## Health Practitioners Competence Assurance Act 2003

### **Responsible authorities**

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

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

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

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

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

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

### **Health Practitioners Disciplinary Tribunal**

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

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

## **Human Assisted Reproductive Technology Act 2004**

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

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

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

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

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

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

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

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

### **District inspectors**

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

## Medicines Act 1981

### **Medicines Adverse Reactions Committee**

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

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

## **Medicines Assessment Advisory Committee**

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

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

## **Medicines Classification Committee**

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

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

## **Medicines Review Committee**

The Medicines Review Committee's functions are to:

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

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

### **Mental Health Review Tribunal**

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

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

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

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

## Misuse of Drugs Act 1975

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

The Expert Advisory Committee on Drugs:

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

## New Zealand Public Health and Disability Act 2000

### **Cancer Control New Zealand**

Established under section 11 of the New Zealand Public Health and Disability Act 2000, Cancer Control New Zealand provides an independent, sustainable focus for cancer control. Cancer Control New Zealand leads the sector in horizon scanning for future trends, thereby helping to reduce the incidence and impact of cancer, evaluate system effectiveness, reduce inequalities and promote research with respect to cancer. Cancer Control New Zealand provides advice and recommendations to the Minister.

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

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

## **National Ethics Advisory Committee**

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

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

## Psychoactive Substances Act 2013

### **Psychoactive Substances Appeals Committee**

The function of the Psychoactive Substances Appeals Committee is to determine appeals against decisions of the Psychoactive Substances Regulatory Authority made by or under the Psychoactive Substances Act 2013.

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

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

## Radiation Protection Act 1965

### **Radiation Protection Advisory Council**

The functions of the Radiation Protection Advisory Council are to advise the Director-General of Health on applications for licences to use irradiating apparatus and/or radioactive materials. It also advises the Minister in respect of regulations under the Radiation Protection Act 1965, the exercise of the Minister's powers, and other matters, including those referred to it by the Minister.

# Appendix 4: Public hospitals in New Zealand

Public hospitals in New Zealand are listed in the table below, by DHB area.

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

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