

Briefing for Incoming Minister

Contents

Part 1: Introduction	4
Role of the Minister of Health	4
Health status	6
Part 2: Structure of the Health and Disability Sector	10
Overview	10
Structural Changes During the 1990s	
Ministry of Health	12
Advisory Bodies	12
National Advisory Committee on Health and Disability	
Mental Health Commission	
Māori Health Commission	
Other National Bodies	13
Health Research Council of New Zealand (HRC)	
Office of the Health and Disability Commissioner	
Health Sponsorship Council	
Alcoholic Liquor Advisory Council of New Zealand (ALAC)	
Health Funding Authority (HFA)	14
Pharmaceutical Management Agency Limited (PHARMAC)	
Health Benefits Limited (HBL)	
Clinical Training Agency (CTA)	
Accident Insurance	16
Hospital and Health Services (HHSs)	17
Share Holding Ministers for Hospital Health Services	
Crown Company Monitoring and Advisory Unit (CCMAU)	
Residual Health Management Unit (RHMU)	
Other Providers	19
Community Trusts	
Private Sector Providers	
Not-for-profit and Charitable Providers	
Professional Organisations	20
Consumer Representative Organisations	21

Part 3: Services 22

Public Health Services	22
Primary Care Services	22
General Practitioners Access to Services	
Pharmaceuticals	26
Secondary and Tertiary Services	26
Access to Services	
Maternity Services	28
Dental Health Services	29
Disability Support Services	29
Access to Services Expenditure	
Mental Health Services	31
Access to Services Expenditure	

Part 4: Nationwide Initiatives for Health 33

Child Health	33
Māori Health	33
Māori Provider Development Scheme	
Pacific Health	34
Mental Health Strategy	35
Youth Suicide Prevention Strategy	36
Strengthening Families	36
Immunisation	38
National Breast Cancer Screening Programme	39
Hepatitis B Screening Programme	40
Cervical Screening	41
National Drug Policy	41
Hospital Services Plan	42
<i>Roadside to Bedside - Acute Management System</i>	43
<i>Healthline</i>	44

Part 5:	Funding and Expenditure	45
	International Comparisons	45
	Trends in Expenditure	45
	Public Expenditure	46
	Health Insurance	47
Part 6:	Legislation	48
	Structural Legislation	48
	Consumer Protection Legislation	48
	Health and Disability Occupations	
	Safety of Health-care and Therapeutic Products	
	Health and Disability Facilities	
	Consumer Rights and Complaints	
	Public Health Legislation	50
	Health Act	
	Food Act	
	Smoke-free Environments Act	
	Other Public Health Legislation	
Part 7:	Health Information	52
	New Zealand Health Information Service (NZHIS)	52
	National Health Index	
	Medical Warning System	
	National Minimum Data Set	
	Standards for Health Information	54
Part 8:	International Linkages	55
	Joint Activities with Australia	55
	World Health Organization	55
Part 9:	The Ministry of Health	57
	Role of the Ministry of Health	57
	Structure	58

Part 1: Introduction

The business of the health and disability sector is to improve and protect health. This means not only preventing and treating illness, but also improving people's quality of life, including independence for people with disabilities. Medical, surgical and other health and disability support services play an essential role in improving health, but while essential, they are not sufficient. Many other factors - from the safety of roads, workplaces, homes and schools, to people's ability to fulfil their basic needs, to exercising and participating in communities - help to build health.

The Government pays for around three-quarters of the services provided, and actively oversees the safety and effectiveness of all services, including privately funded ones.

This volume provides information on:

- the responsibilities of the Minister of Health
- how successful the health and disability sector has been in terms of health outcomes for New Zealanders, including how we compare with similar countries
- the key agencies in the health and disability sector
- the health and disability support services available to people in New Zealand
- national strategies and initiatives
- trends in public and private expenditure on health and disability support services
- the legislative framework.

Role of the Minister of Health

The Minister of Health is responsible to Parliament for the exercise of the functions, duties or powers given to him or her by the legislation.

In terms of the Health and Disability Services Act 1993, these responsibilities include:

- notifying the Health Funding Authority (HFA) of the objectives of the Crown. This can be considered the first stage of the purchasing process and its associated accountability cycle.
- negotiating and entering into a Funding Agreement with the HFA and monitoring the performance of the HFA. This is the central part of the purchasing process. The Ministry of Health, as the agent of the Minister, leads this process.
- appointing persons to investigate or inquire into the purchase or provision of health and disability support services.

The Minister of Health also has powers under other Acts, for example, to:

- issue licences for hospitals (Hospitals Act 1957)
- appoint members to occupational registration boards
- authorise Medical Officers of Health to use their special powers in controlling infectious disease outbreaks (Health Act 1956).

Under constitutional convention, the Minister of Health is accountable to Parliament for the activities of the Ministry of Health and, more generally, for the way those who work in the health and disability sector exercise their powers and duties. This accountability includes:

- investigating claims that someone working in the health and disability sector may have used their powers improperly
- taking action to remedy any claims that are found to be justified
- reporting to Parliament on the results of these actions.

The Minister of Health has ‘ownership’ responsibility for the following Crown Entities:

- Health Funding Authority (HFA)
- Alcoholic Liquor Advisory Council of New Zealand (ALAC)
- the Office of the Health and Disability Commissioner (HDC)
- Health Research Council of New Zealand (HRC)
- Health Sponsorship Council
- Mental Health Commission
- Residual Health Management Unit (RHMU).

The Health and Disability Services Act 1993 established shareholding Ministers for Crown health enterprises (now known as Hospital and Health Services). The shareholding Ministers are responsible for ensuring that investment in capital and human resources is managed wisely. In recent years the Minister of Health has also held the portfolio of Minister for Hospital and Health Services.

Unlike the departmental structures underpinning some other ministerial portfolios, the functional responsibilities in the health system are spread across a number of organisations. Consequently there are some key relationships for the Minister of Health to ensure that the Government’s health policy objectives are achieved.

The Director-General of Health is the Chief Executive of the Ministry of Health and is the Minister’s principal advisor on the health and disability sector. Each year, the Director-General of Health negotiates a purchase agreement which sets out the Key Result Areas and outputs that the Ministry of Health will produce. The Director-General has statutory powers, for example, in relation to control of communicable disease.

In addition to the Ministry of Health, there are other independent sources of advice to the Minister of Health, including the National Advisory Committee on Health and Disability and the Mental Health Commission.

Health Status

Life expectancy at birth has improved during the last four decades in New Zealand. In 1997 women lived to an average age of 79.6 years, and men lived to an average age of 74.3 years (Figure 1).

Over the past two decades, Māori life expectancy has increased significantly and Māori infant mortality rates have continued to decline. However, Māori life expectancy and mortality rates are still worse than those of non-Māori (Figure 2).

Māori tend to have higher death rates than non-Māori in most general areas of disease. Causes of death showing disproportionately high rates for Māori compared with non-Māori include diabetes, lung cancer and cardiovascular disease. The death rate from diabetes for Māori is almost six times that of non-Māori.

Figure 1: Life Expectancy at Birth 1960 - 1997

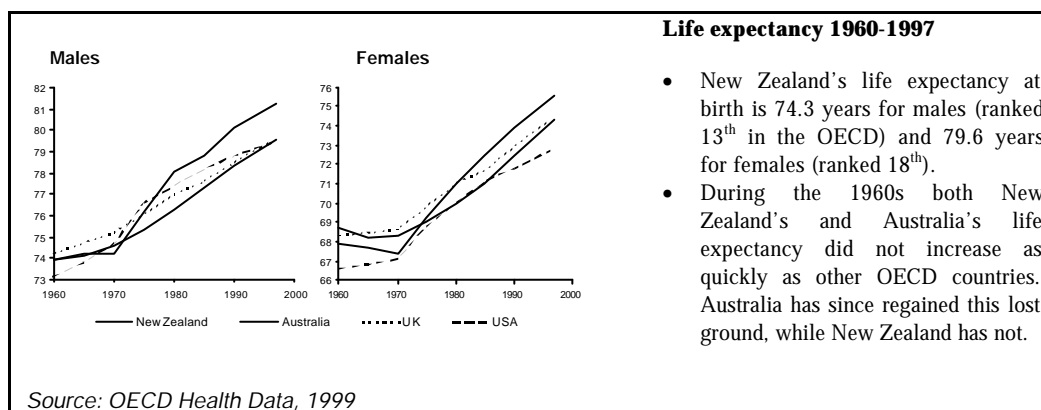
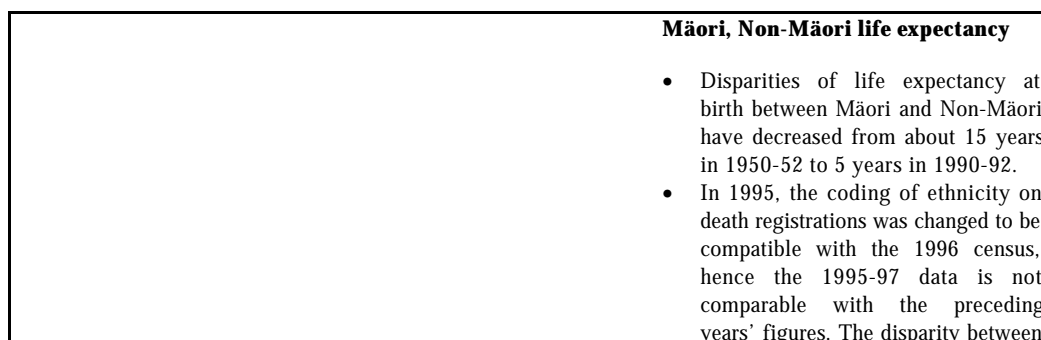
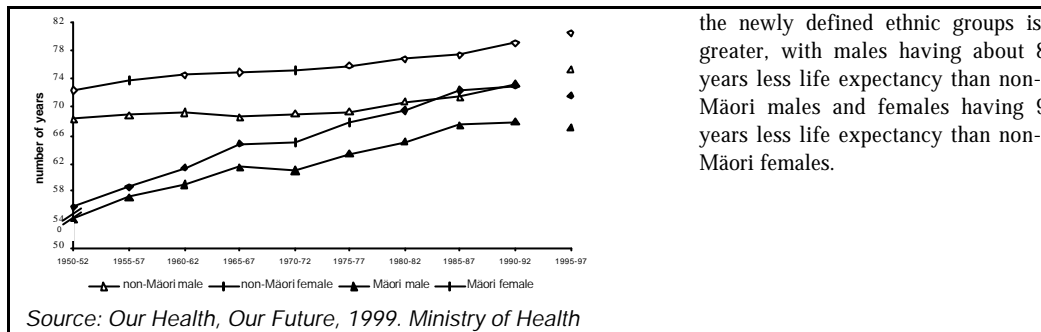


Figure 2: Life Expectancy at Birth, by Ethnicity and Gender, 1950 - 1997





the newly defined ethnic groups is greater, with males having about 8 years less life expectancy than non-Māori males and females having 9 years less life expectancy than non-Māori females.

The health status of Pacific people in New Zealand is poorer than that of non-Pacific people, but generally occupies an intermediate position between Māori and non-Māori.

New Zealanders' comparatively high mortality rates for ischaemic heart disease, cerebrovascular disease, respiratory disease, and some cancers relate to risk factors such as smoking, poor diet and lack of exercise. Māori have a high prevalence of these risk factors, explaining, in part, their higher mortality rate.

Poor nutrition and lack of exercise contribute to premature mortality in New Zealand, in particular deaths from cardiovascular disease, cancers (especially bowel cancer), diabetes and alcohol-related diseases. The incidence of these diseases can be reduced by changes in diet and exercise.

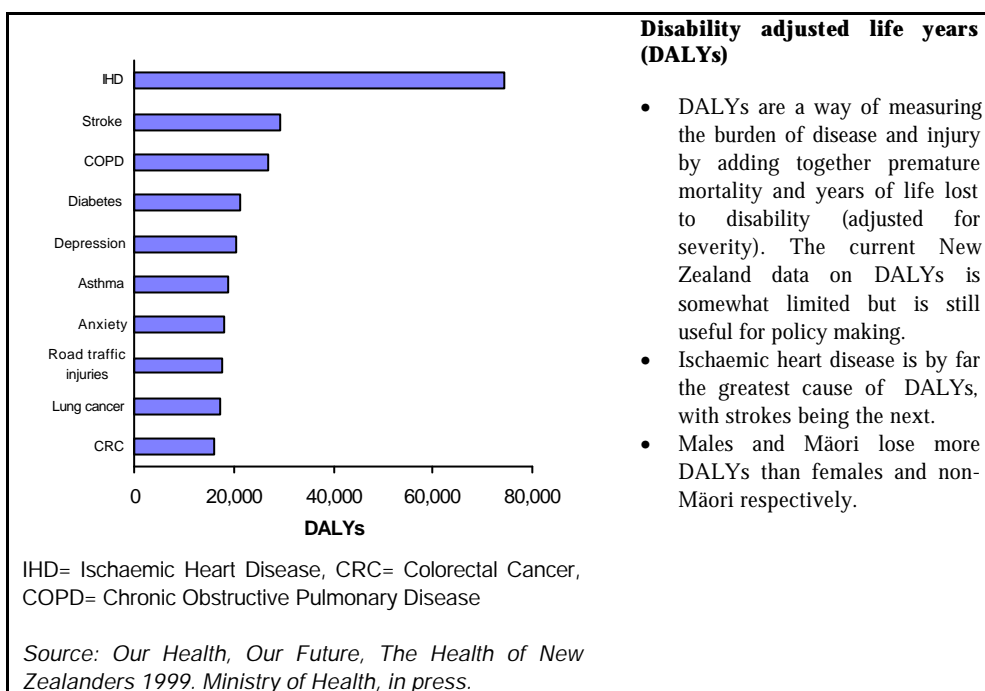
The health impact of smoking tobacco is serious, and a range of health sector interventions have the objective of reducing smoking. Half of all lifetime smokers die earlier than if they did not smoke. The burden of death from smoking is evident in a range of areas:

- most frequently, it causes adult deaths from cardiovascular disease and lung cancer
- numerous other diseases have smoking as a component cause
- smoking by adults increases children's risk of sudden infant death syndrome (SIDS) and respiratory illness.

In addition, improved early detection and treatment (often by screening based in primary care) of high blood pressure, diabetes, asthma, cervical cancer and breast cancer can delay or prevent a significant proportion of deaths.

The enormous burden of young male lives lost through suicide and motor vehicle crashes (which together are higher than either cancer or ischaemic heart disease as causes of potential years of life lost for men) may relate to our cultural attitudes towards, or expectations of, young people, and particularly towards risk-taking behaviour in young men. Health services may contribute to preventing suicide through participating in inter-sectoral initiatives to prevent the development of risk factors for suicide and improving the early detection and treatment of mental health problems. The health and disability sector must continue to participate in inter-sectoral and community programmes, road safety, drug and alcohol control, and increasing community acceptance of people who seek treatment for mental illness.

Figure 3 ; DALYs for Top Ten Causes, 1996



New Zealand has comparatively high infant (age under 12 months) mortality rates. Neonatal and perinatal (age up to 28 days) mortality rates are low compared with other OECD countries, suggesting that the standard of antenatal and obstetric care is good. Post-neonatal infant mortality and SIDS are more common when the mother is of lower socioeconomic status, young, unmarried and with limited education. Particularly for SIDS, early motherhood, inexperience and lack of support interrelate with smoking and lack of breastfeeding. Reduction in the number of unsupported young mothers, and increased social support and parenting skills are needed to reduce deaths for very young children. The part that health services can play in achieving this social change is through well child services co-ordinated with other sectors, particularly with the development of intensive home-visiting support for families at risk of multiple disadvantage.

About 70 percent of premature deaths and a great proportion of morbidity in the 0-74 age group is avoidable.

Figure 4: Infant Mortality Rate, 1960 - 1997

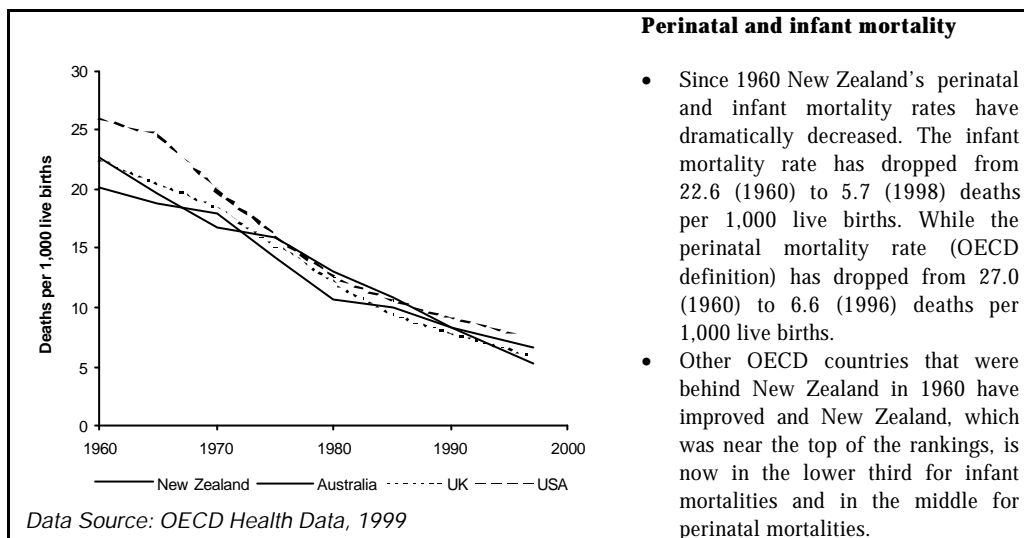
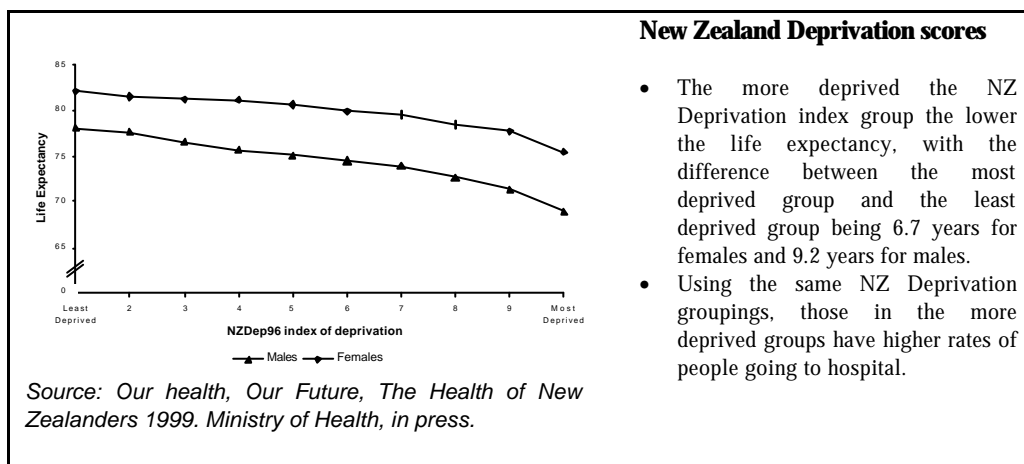


Figure 5: Life Expectancy at Birth, by NZDep96, 1995 - 1997



Part 2: Structure of the health and disability sector

Overview

New Zealand's health system is predominantly publicly funded. On average \$1,500 of public funds is spent annually on the health and disability support needs of each New Zealander.

Health and disability support services in New Zealand are provided by a mix of publicly owned, privately owned and not-for-profit providers. Publicly owned hospitals provide most secondary medical and surgical care, while most primary care is provided by publicly subsidised but privately owned general practices. The private hospital sector specialises mainly in elective surgery and long-term geriatric hospital services. A wide range of not-for-profit providers and other providers are involved in disability support services.

Structural Changes During the 1990s

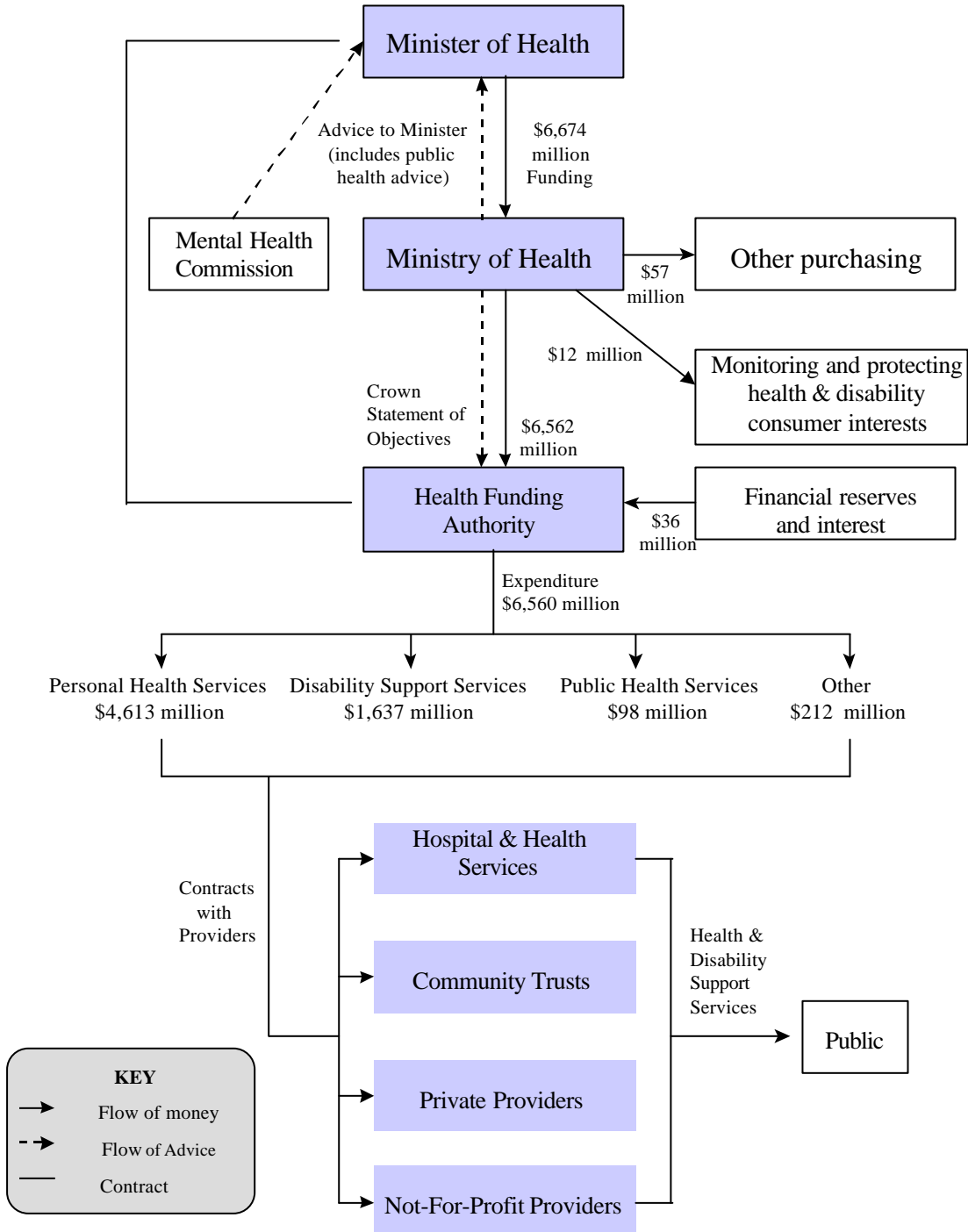
New structures were established in 1993 with some subsequent modifications. Key structural changes were:

- The Department of Health shed the majority of its operational functions and became the Ministry of Health, which focuses on developing policy, monitoring of performance, providing Ministerial support services, and administering legislation and regulation.
- Area health boards were initially replaced with:
 - four regional health authorities (RHAs) purchasing all personal health and disability support services
 - Crown health enterprises (now Health and Hospital Services), each centred on a major public hospital, as the new publicly owned providers of health care services.
- The Public Health Commission (PHC) was established to purchase public health services. From July 1995 the Public Health Commission was disestablished, with public health policy functions moving back into the Ministry of Health and the RHAs taking over responsibility for purchasing public health services.

As of 1 July 1997, the four RHAs were amalgamated into one health authority, and from 1 January 1998 this organisation has operated as the Health Funding Authority (HFA).

The current health and disability sector structure, along with funding levels, are shown in Figure 6.

Figure 6: Vote Health 1999/2000 (GST incl.)



Ministry of Health

The Ministry of Health is responsible for:

- providing the Minister of Health and the Government with advice on policy for health and disability support services, and on health implications of policies in other sectors
- providing Ministerial and Parliamentary information and support services
- acting as the Minister of Health's agent for administering public funding to the sector, negotiating Funding Agreements with the HFA and monitoring its performance
- protecting, promoting and improving public health, and reporting annually on the state of public health
- monitoring the overall performance of the sector
- administering health and disability sector legislation and regulations
- collecting and disseminating national health information.

The Ministry of Health has a separate purchase agreement with the Minister of Biosecurity.

The Chief Executive of the Ministry, the Director-General of Health, is employed by the State Services Commission on a time-limited contract, as are all other departmental chief executives.

Details on the Ministry's role and structure are provided in Part 9 of this volume.

Advisory Bodies

National Advisory Committee on Health and Disability (NHC)

The NHC (formerly the National Advisory Committee on Core Health and Disability Support Services) has a statutory function under section 6 of the Health and Disability Services Act 1993 to give independent advice to the Minister of Health on:

- the kinds, and relative priorities, of public health, personal health services and disability support services that should be publicly funded
- other personal health and regulatory matters impacting on public health (public health functions were added after the disestablishment of the Public Health Commission in July 1995)
- such other matters as the Minister specifies by notice to the NHC.

The current focus of the NHC is on providing advice to the Minister on the HFA's purchasing intentions. The NHC is serviced by the Ministry of Health.

Mental Health Commission

The Mental Health Commission was established by the Government in 1996 to oversee the implementation of the Government's decisions following the 1996 Mason Inquiry. The Commission's functions are to:

- ensure full implementation of *Looking Forward*, the national mental health strategy
- work with the Ministry of Health and the HFA to promote a better public understanding of mental illness and reduce the associated stigma and prejudice
- work with the Ministry, the HFA and providers to lift the image of mental health provision as a career alternative and to address mental health workforce issues by these means.

Māori Health Commission

The Māori Health Commission provides advice to the Government, through the Minister of Māori Affairs, on issues of Māori health.

Other National Bodies

Health Research Council of New Zealand (HRC)

The functions of the HRC, which is governed by the Health Research Council Act 1990, include to:

- initiate, fund and support health research
- foster recruitment and training of health researchers
- promote and disseminate the results of health research
- advise the Minister of Health on national health research policy.

The members of the HRC are appointed by the Minister of Health. HRC funding for research is sourced from the Ministry of Research, Science and Technology.

Office of the Health and Disability Commissioner

The Office of the Health and Disability Commissioner was established in 1994 to protect the rights of consumers of health and disability support services.

The functions of the Commissioner include to:

- develop a Code of Rights, and periodically review the Code
- promote rights of consumers of health and disability support services
- investigate potential breaches of the Code
- refer complaints for investigation, and decisions on action
- prepare guidelines for the operation of advocacy services
- report to the Minister of Health.

The Health and Disability Commissioner (Code of Health and Disability Services Consumer Rights) Regulations 1996 came into force on 1 July 1996. The Office of the Commissioner also incorporates the Director of Proceedings and the Director of Advocacy, both of whom are required to act independently of the Commissioner.

The Director of Advocacy maintains a network of patient advocates to support people to attain their rights. Where matters are very serious, or the patient advocate is unable to resolve them, they may be referred to the Health and Disability Commissioner.

Health Sponsorship Council

The Health Sponsorship Council was established under the Smoke-free Environments Act 1990. Its principal function is to promote health and encourage healthy lifestyles. The Council provides sponsorship for sporting, artistic, cultural and recreational organisations in return for the promotion of healthy lifestyle messages such as 'smokefree', 'street skills' and 'sun smart'.

Alcoholic Liquor Advisory Council of New Zealand (ALAC)

ALAC is a Crown agent, established under the Alcoholic Liquor Advisory Council Act 1976. ALAC has the Cabinet-agreed objective of promoting moderation in the use of alcohol, and the development and promotion of strategies which will reduce alcohol-related problems for the nation.

There is a Letter of Arrangement between the Minister of Health and ALAC. Reports include:

- monthly financial reports
- a strategic plan and business plans for the Minister's endorsement
- annual report.

Health Funding Authority (HFA)

Most of the Government's spending on health and disability support services is channelled through the HFA. The HFA buys publicly funded health and disability support services, on behalf of New Zealanders, from a wide variety of providers. The purpose of the HFA is to allocate resources to enhance and maintain the health and independence of New Zealanders. The HFA is responsible for purchasing public health, personal health and disability support services. It is also responsible for purchasing postgraduate clinical training.

The Health and Disability Services Act 1993 specifies the various functions and objectives of the HFA. These include:

- monitoring the need for public health, personal health and disability support services
- purchasing these services
- monitoring the performance of contracted providers
- promoting people's personal health

- promoting care and support for those in need of personal health services or disability support services
- promoting the independence of people with disabilities
- improving, promoting and protecting public health.

The HFA contracts with a variety of publicly and privately owned providers and voluntary organisations. The HFA has a Funding Agreement with the Minister of Health. The agreement sets out:

- the range of health and disability support services and public health services which the HFA must fund for the population
- funding levels for purchasing services
- the financial and organisational operating environment
- information and monitoring requirements.

The HFA is a national organisation with five locality offices in Auckland, Hamilton, Wellington, Christchurch and Dunedin. National Operating Groups (Personal Health, Public Health, Mental Health and Disability Support) and a Māori Health Group provide for a national focus, while the locality offices allow for local community needs to be taken into account when funding services.

PHARMAC, Health Benefits Limited and the Clinical Training Agency are all specialised agencies that are owned by the HFA.

Pharmaceutical Management Agency Limited (PHARMAC)

PHARMAC's role is to manage the national Pharmaceutical Schedule of the HFA. PHARMAC seeks to balance the needs of patients for equitable access to health care with the needs of taxpayers for management of public money.

The Pharmaceutical Schedule is a list of almost 3,000 subsidised prescription drugs and related products available in New Zealand. The Schedule also records the price of each drug, the subsidy it receives from public funds and the guidelines or conditions under which it can be prescribed.

Decisions are taken by PHARMAC with input from independent experts through the Pharmacology and Therapeutics Advisory Committee (PTAC).

Health Benefits Limited (HBL)

When people go to see a general practitioner (GP) or collect medicine from a pharmacy, some or all of the cost of their visit or medicine may be paid for by the Government, for example, for all children under six years. Most GPs and pharmacists claim this subsidy through HBL, which processes over \$1 billion in claims every year.

HBL also works to prevent fraud, and provides the HFA and GP groups with information about use of health services in the community so that these services can be continually improved.

Clinical Training Agency (CTA)

The CTA is responsible for funding post-entry clinical training in the health and disability sector. (Undergraduate or 'pre-entry' training is funded by the education sector.)

The HFA allocates \$70 million every year to the CTA for training in the areas of medical, nursing, mental health, public health, pharmacy, and allied health fields including programmes aimed at improving the delivery of health and disability support services to Māori.

Accident Insurance

The accident insurance market and the role of the Accident Rehabilitation and Compensation Insurance Corporation were changed by the Accident Insurance Act, which took effect from 1 July 1999.

The Act maintains a no-fault, comprehensive insurance-based scheme. The Act establishes work accidents as a competitive market, requiring employers to purchase accident insurance for work-related personal injuries suffered by their employees. Employers are able to choose from private insurers or a new State-owned Enterprise (SOE).

The Act establishes the Accident Compensation Corporation (ACC) as the successor to the Accident Rehabilitation and Compensation Insurance Corporation. ACC will primarily be responsible for delivery of the non-competitive elements of the scheme, that is, accidents other than work accidents. This includes delivering, establishing and operating an insurance-based scheme to rehabilitate and compensate persons who suffer personal injury (as defined under section 29 of the Accident Insurance Act). ACC is the default insurer for the self-employed for work accidents if they do not choose an insurer.

ACC continues to have the role of reducing the social, economic and physical impact of personal injury on individuals and the community.

ACC continues to pay for health care services in the non-competitive parts of the market, where health and disability support services are required as a result of accidents. This takes place through three primary methods:

- subsidies for individuals (for example, physiotherapy fees)
- reimbursement to the Crown (for public health acute services)
- direct payments to the HFA for elective health services.

Insurers will be required to pay for health services, except for public health acute services. Public health acute services will be paid for by the HFA, and insurers will be charged a levy to cover these costs.

Hospital and Health Services (HHSs)

HHSs were created under the Health and Disability Services Act 1993 as Crown health enterprises to provide health and/or disability support services. Their names were changed in a 1998 amendment to the Act.

Other public hospital objectives specified by the Act are to:

- assist in meeting the Crown's objectives under the Act
- exhibit a sense of social responsibility by having regard to the interests of the communities in which they operate
- uphold the ethical standards generally expected of providers of health and disability support services
- be good employers
- be as successful and efficient as comparable businesses that are not owned by the Crown.

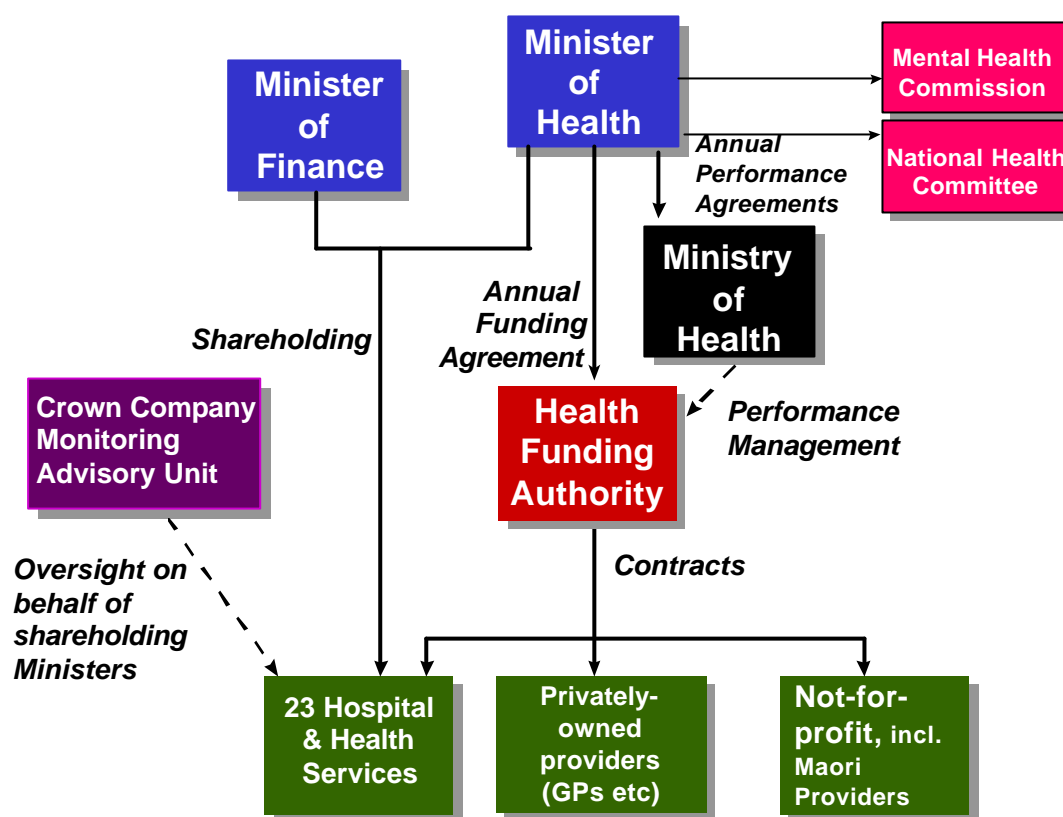
HHSs contract with the HFA to provide hospital and related services, community-based services, and public health services. They operate in a framework of commercial law (such as the Companies Act and the Commerce Act).

Smaller hospitals offer an expert service in the types of care they provide, but pass on the most complex cases to the bigger hospitals where there is a greater range of specialities. At present, New Zealand has five large tertiary public hospitals providing the most specialised and complex medical care.

There are presently 22 HHSs, based on previous area health board hospitals, running 93 premises. A separate HHS runs the blood service for New Zealand.

The New Zealand Blood Service (NZBS) was established under the Health and Disability Services Act 1993 but appointed as the agency responsible for the collection and provision of New Zealand's blood and blood services under Part 3a, 92h of the Health Act 1956 (amended 1998). The NZBS became operational from 1 July 1998 from three sites: Auckland, Wellington and Christchurch. During 1999 and 2000 the NZBS will assume responsibility for running blood services throughout the remainder of the country. The NZBS differs from other HHSs principally by the range of services it provides and because its primary relationship is with other HHSs and providers and not with the HFA.

Figure 7: The publicly funded health and disability support system



Shareholding Ministers for Hospital and Health Services

The Health and Disability Services Act 1993 establishes shareholding Ministers for HHSs. These Ministers are the Minister for HHSs and the Minister of Finance. They are responsible for ensuring that taxpayer investment in capital and human resources is managed wisely.

The major roles of the shareholding Ministers are to appoint HHS Boards and to approve the business plans of HHSs, including any requests for investment.

The principal advisor and agent for shareholding Ministers is the Crown Company Monitoring and Advisory Unit.

Crown Company Monitoring and Advisory Unit (CCMAU)

CCMAU is an operational unit of the Treasury that is responsible for:

- advising the Government on ownership objectives for public hospitals, the Crown’s capital investment in HHSs, and the impact on public hospitals of proposed health policy options

- monitoring and advising Ministers on public hospital performance
- managing, on behalf of Ministers, director appointments and the process for assessing the performance of HHS Boards.

CCMAU also advises the Government on ownership issues relating to State-owned Enterprises and Crown Research Institutes.

Residual Health Management Unit (RHMU)

The Health Reforms (Transitional Provisions) Act 1993 established the RHMU and its purpose. The principal activities for the RHMU are to:

- manage HHS debt arising from Area Health Boards
- lend new debt to HHSs
- promote sustainable financial structures for HHSs
- manage contingent liabilities and residual assets of Area Health Boards
- manage patients' frozen interest funds.

Although the Minister of Health is the responsible Minister by statute, this responsibility has been shared with the Minister of Finance following an administrative decision in 1994.

Other Providers

Most primary care services (including GPs, nursing, dental, physiotherapy and other practices), pharmacies and rest homes are privately owned, although they receive varying degrees of public funding.

Community Trusts

A number of smaller communities have established community trusts to develop health services for people in their area. Some of these groups have expressed interest in taking over the local hospital premises.

In May 1996, the Government made available \$11 million over two years to help community groups involved in local health services buy surplus hospital facilities from the Crown. The funds were provided as a loan with a term of five years, with repayment required only if the community groups cease to provide health services or the contract to provide services is not renewed by the HFA.

Examples of community trusts are:

- the Tuapeka Community Health Company, which provides integrated general practice, district nursing and long-stay services in Lawrence
- Te Oranganui in Wanganui providing integrated primary and community services
- Hauora Hokianga providing integrated community and specialist services in Northland.

Private Sector Providers

Most primary care services (including GPs, nursing, dental, physiotherapy and other practices) are privately owned but receive varying degrees of public funding for services.

Private medical, surgical and long-stay hospitals are concentrated in the main population centres. There are 243 privately operated hospitals, providing 8,132 beds. The majority of these hospitals are for care of older people.

Major representative bodies of privately owned providers include:

- New Zealand General Practitioners Association
- Pharmacy Guild of New Zealand
- New Zealand Hospitals Association
- New Zealand Licensed Resthomes Association.

Not-for-profit and Charitable Providers

Not-for-profit health services are provided by more than 50 national organisations (and many more local providers), many of which derive large parts of their labour from volunteers. These organisations tend to derive at least part of their income from donations, but their services are largely purchased by the HFA. Some of the major providers include the IHC, New Zealand CCS, the Plunket Society, the New Zealand Family Planning Association, the Salvation Army (drug and alcohol services), the Red Cross, the Royal New Zealand Foundation for the Blind and Presbyterian Support Services. The New Zealand Federation of Voluntary Welfare Organisations and the New Zealand Council of Christian Social Services provide a national voice for voluntary providers.

Professional Organisations

A range of professional bodies represent the interests of the different health professional groups in different ways.

Statutory regulatory bodies (such as the Medical Council or the Nursing Council) are responsible for qualifications, registrations, practice and discipline. They play a powerful role in the direction of the sector. The professional colleges (for example, College of Nurses) work with the councils to set standards for registration, and take responsibility for ongoing professional training.

Professional associations such as the New Zealand Nurses Organisation, the Pharmaceutical Society and the New Zealand Medical Association take care of professional issues, and represent their members' interests in either a trade union role (for example, nurses' salaries) or a provider role (for example, in maternity benefit negotiations).

Consumer Representative Organisations

There is a wide range of consumer organisations in the health and disability sector, most organised around a specific health condition or disability. Apart from representing or advocating for their constituent groups, many also provide counselling, education and information.

Organisations around specific conditions include:

- Alzheimer's Society of New Zealand
- Arthritis Foundation of New Zealand
- Asthma and Respiratory Foundation
- Cerebral Palsy Society
- Cystic Fibrosis Association of New Zealand
- Deaf Association of New Zealand
- Epilepsy Association of New Zealand
- Haemophilia Society
- Mental Health Foundation
- New Zealand AIDS Foundation
- New Zealand Cancer Society
- Schizophrenia Fellowship.

Some of these groups have become providers in their own right, being contracted by the HFA to provide information and support services.

The Assembly of People with Disabilities in New Zealand (Disabled People's Assembly) provides a forum for individuals with disabilities and their family members, and consumer and provider agency representatives, to discuss and promote issues of mutual concern.

Part 3: Services

Public Health Services

Public health services affect the safety of the air we breathe, the water we drink, and the food we eat.

Inter-sectoral activities related to public health involve monitoring, auditing, collaborating and providing advice on the public health impact of policies, programmes and services in other sectors. Current inter-sectoral initiatives include *Strengthening Families* (an interdepartmental strategy co-ordinated by the Department of Social Welfare that aims to enhance the capacity and self-reliance of families and whānau in their role of raising healthy and capable individuals), and the National Drug Policy (see Part 4).

Population-based health promotion and protection services and programmes are purchased by the HFA from public health funding. These include programmes to promote good nutrition, exercise and non-smoking, injury prevention services, and programmes to improve Māori health status. Some of these services are local or regional but for other services the HFA purchases national programmes.

Public health aspects of personal health services include health promotion and disease prevention activities such as immunisation and screening programmes (see Part 4 for further detail).

Some HHSs provide health protection services and health promotion services such as smokefree, nutrition and alcohol programmes. Medical Officers of Health, Health Protection Officers, and Smokefree Officers are employed by HHSs, and enforce public health legislation, such as the Health Act 1956, the Food Act 1981, the Toxic Substances Act 1981 and the Smoke-free Environments Act 1990, as well as undertaking functions under other legislation such as the Biosecurity Act 1993 and the Resource Management Act 1991.

Not-for-profit providers, such as the New Zealand AIDS Foundation, the Cancer Society, and the Heart Foundation, provide other specific health promotion and advocacy services. The Health Sponsorship Council provides sponsorship and funding for sports and other activities in return for the promotion of healthy lifestyle messages.

Primary Care Services

Primary health care services are often the first and most common point of contact with health professionals. These may also be referred to as community services as they are delivered in the community rather than in a hospital setting.

Services include:

- health promotion and education for individuals
- screening and preventive care
- care and support for chronic conditions
- emergency care, including resuscitation and stabilisation
- referral to other services.

General Practitioners

General practitioners (GPs) in New Zealand work in privately owned practices, which are predominantly owned by the GPs themselves. About 80 percent of GPs are members of Independent Practitioner Associations (IPAs). The Government pays a subsidy to GPs, which contributes to fees paid to GPs by patients. The subsidy is usually made on a consultation-by-consultation basis, an arrangement which is commonly known as fee-for-service. Alternatively, in an arrangement known as capitation, a practice may receive its subsidy in a block sum for which it is required to look after an enrolled population.

Not all patients are subsidised, so GPs charge patients for part, or all, of a consultation (also called a co-payment). Table 1 shows the level of subsidy paid by the Government.

It is estimated that over 16.1 million GP consultations (subsidised and unsubsidised) occur in New Zealand in any given year. Of these, about 70 percent, or over 11 million visits, are subsidised by the Government.

The Government endeavours to ensure that access to GP services is not prohibited by cost by specifically targeting benefits to lower income earners and higher users of health services.

Access to Services

Community Services Cards

Community Services Cards (CSCs) are available for beneficiaries and people on low incomes. These cards entitle an individual or family to access a higher Government subsidy on visits to the GP and on pharmaceuticals. As a result, any part charge (co-payment) normally required by the GP should be reduced by the amount of the additional subsidy. Table 1 shows the current CSC subsidies.

In 1997 1.1 million adults held CSC cards. The cards also cover their children, and the CSC Centre estimate about 1.3 million people, in total, are included in CSC cards. Not all eligible people choose to have a Community Services Card.

High Use Health Cards

High Use Health Cards (HUHCs) are intended to ensure that costs are not a barrier to accessing GPs and pharmaceuticals for people with high health needs. Eligibility for HUHC benefits is determined by the number of GP consultations (minimum of 12 in any 12 month period) for an

ongoing condition(s) and is not affected by an individual's income. These cards entitle the holders to access a higher Government subsidy on visits to GPs or on pharmaceuticals. Table 1 lists the current HUHC subsidies.

As at 1 July 1997, 63,443 people held HUHCs.

Pharmaceutical Subsidy Cards

The pharmaceutical subsidy card (PSC) entitles individuals/families access to lower pharmaceutical costs after 20 prescription items for which a charge was paid.

Free Primary Care for Under-Sixes

The Government provides a subsidy to GPs for all consultations with children. For children under six the GP receives a subsidy of \$32.50, which means most GPs in New Zealand do not need to set a part charge, except for after-hours service.

All children six years and over have their visits to GPs subsidised. Children who have HUHCs or whose parents have a CSC attract a higher level of subsidy.

Primary Care Referred Services (laboratory, x-ray, pharmaceuticals)

GPs commonly prescribe pharmaceuticals, and order diagnostic tests such as laboratory tests and x-rays. These are often grouped as primary care referred services. More Government money is spent on these services than any other primary health care services.

Table 1 User Charges for Services

Service	Description and basis of user charge
Inpatient	<ul style="list-style-type: none"> No user charge
Outpatient	<ul style="list-style-type: none"> No user charge
Lab/Diagnostic Tests	<ul style="list-style-type: none"> Lab tests are free, except for insurance certificates etc Radiologist subsidies apply for non-maternity pelvic and abdominal ultrasound, mammogram and barium enema Most diagnostic tests referred to private radiology clinics are full cost to the patient Diagnostic tests referred as part of outpatient treatment are free
GP Visits	<ul style="list-style-type: none"> Full cost for people aged 16 years and over (average fee of \$33.50 but wide variations) \$15 subsidy for children aged over 6 years without a family CSC \$15 subsidy for adult CSC holders \$20 subsidy for children with a CSC or dependant of a CSC holder \$15 subsidy for adults with an HUHC \$20 subsidy for children aged over 6 years with HUHC \$32.50 subsidy for children under 6 years
Prescription Pharmaceuticals	<ul style="list-style-type: none"> Pharmaceuticals are subject to targeted per-item fees within a maximum: <ul style="list-style-type: none"> No charge to children under 6 (with minor exceptions) \$15 per item for adults maximum charge (non-CSC holders) \$10 maximum per item for children over 6 \$3 per item for CSC holders \$3 per item for HUHC holders \$2 per item for PSC holders \$0 per item CSC plus PSC \$2 per item HUHC plus PSC \$0 children under 6 years No charge for inpatient and outpatient prescribed medication <p>NOTE: A manufacturer's premium may apply when the price exceeds the HFA subsidy, but in almost all therapeutic subgroups there is at least one fully subsidised item.</p>
Maternity	<ul style="list-style-type: none"> No charge at primary or secondary care level, except for private provision of non-HFA subsidised services
Accident	<ul style="list-style-type: none"> ACC covers up to \$26 of GP costs (\$32.50 for under-sixes), free outpatients, reduced costs of diagnostic tests, physiotherapy etc
Dental	<ul style="list-style-type: none"> Dental services are provided free for pre-school and dependent children Dental services are provided free if part of inpatient treatment. The public hospital outpatient dental user charges predate the hospital user charge regime. Adult CSC holders requiring immediate treatment for pain pay a maximum of \$35 per visit in some areas (the essential dental care programme)
DSS Needs Assessment and Service Co-ordination	<ul style="list-style-type: none"> No charge
DSS Caregiver Support (including respite care)	<ul style="list-style-type: none"> No charge
DSS Environmental Support Services (equipment, home)	<ul style="list-style-type: none"> User charge for some environmental support services is \$37 per item, but can be waived for financial hardship

alteration grants, purchase of car etc)	<ul style="list-style-type: none"> • Maximum \$37 user charge for equipment • Home alterations and assistance with purchase of a motor vehicle above certain values may be subject to an income and asset test on a case-by-case basis
DSS Residential Care and Support (for under 65s)	<ul style="list-style-type: none"> • Free to children • If client is receiving an income support benefit, the benefit goes towards the cost of care, with client receiving a weekly personal allowance (a form of income testing)
DSS Residential Care and Support (for over 65s)	<ul style="list-style-type: none"> • Income and asset testing for residential care at rest home or hospital level irrespective of the status of the provider • Maximum user charge of \$636 per week if the <i>contracted</i> price of the level of care is greater than \$636 per week
DSS Home Support and Personal Services	<ul style="list-style-type: none"> • Free to CSC holders or those income tested as at benefit level • Income tested for non-CSC holders
Travel and Accommodation	<ul style="list-style-type: none"> • Regional variations in level of assistance but usually targeted to CSC or HUHC holders (ie, the HFA uses an existing targeting regime to 'piggy back')
Public Health	<ul style="list-style-type: none"> • No charge (apart from non-schedule immunisations and vaccines)

Pharmaceuticals

New Zealand has a Pharmaceutical Schedule which prescribes the levels of government funding for different pharmaceuticals (medicines and therapeutic medical devices) and any restrictions or guidelines regarding the prescribing or dispensing of pharmaceuticals.

PHARMAC, the Pharmaceutical Management Agency owned by the HFA, is responsible for managing the Pharmaceutical Schedule. The Schedule is divided into therapeutic groups (pharmaceuticals used to treat the same condition, for example, ulcer healing) and further into subgroups (pharmaceuticals that have the same therapeutic effects, such as H₂ antagonists). The Government then fully subsidises at least one pharmaceutical in each group. In exceptional circumstances, some individuals receive extra assistance with the cost of their medicine, assessed on a case-by-case basis.

The HFA manages pharmaceutical expenditure in two ways: supply-side controls through PHARMAC and demand-side controls.

PHARMAC operates the Schedule on the basis of reference pricing (price competition). It also uses improved targeting and risk-sharing with suppliers to control pharmaceutical expenditure.

On the demand side, the HFA is implementing budget-holding contracts with GPs on an increasingly wide scale, changing contracts with pharmacists, and encouraging more efficient and effective prescribing by GPs and specialists. There is also a range of consumer co-payments for pharmaceuticals which help manage consumer demand and control expenditure.

Secondary and Tertiary Services

Medical services are services involving non-invasive treatment. Surgical services usually involve one or more operative procedures. Medical and surgical services are either acute or elective. Acute services are for urgent conditions which need immediate treatment. Elective services are for conditions which do not need immediate treatment. There are no charges for hospital treatment for inpatients or outpatients treated in public hospitals.

Both public and private sector organisations run hospitals and provide secondary care services, but the government-owned and funded public sector is by far the largest. Historically the private sector has largely restricted itself to the elective surgical procedures, and long-stay geriatric care.

Access to Services

Distance, time and cost are all factors influencing access to services.

Geographic Factors

It is estimated that at least 95 percent of New Zealanders live within one hour's drive of a base hospital providing medical and surgical services. The increasing use of helicopters has reduced access time for emergency care for many people in rural areas. Telemedicine is another development which is bringing diagnosis and treatment closer to patients.

Timing/Scheduling

Waiting for hospital services has been a feature of New Zealand's health service for many years, as it is in many other places in the world. Having grown on an annual basis over many years, waiting lists fell in New Zealand for the first time in 1996/97. The introduction of booking systems and clinical priority assessment criteria have brought about more consistency and fairness in decisions about treatment and timing. Patients are able to be more certain about whether and when they will receive treatment.

Booking systems for elective surgery are being implemented across the country to address problems associated with the old waiting list system. The booking system model uses clinical assessment criteria to establish patients' priority for treatment. Those with the highest clinical priority receive treatment first, while those who do not qualify for treatment are referred back to their GP for follow-up care and monitoring. If their condition changes, they can be referred to the hospital specialist for another assessment.

Charges

There are no charges for hospital treatment for inpatients or outpatients treated in public hospitals.

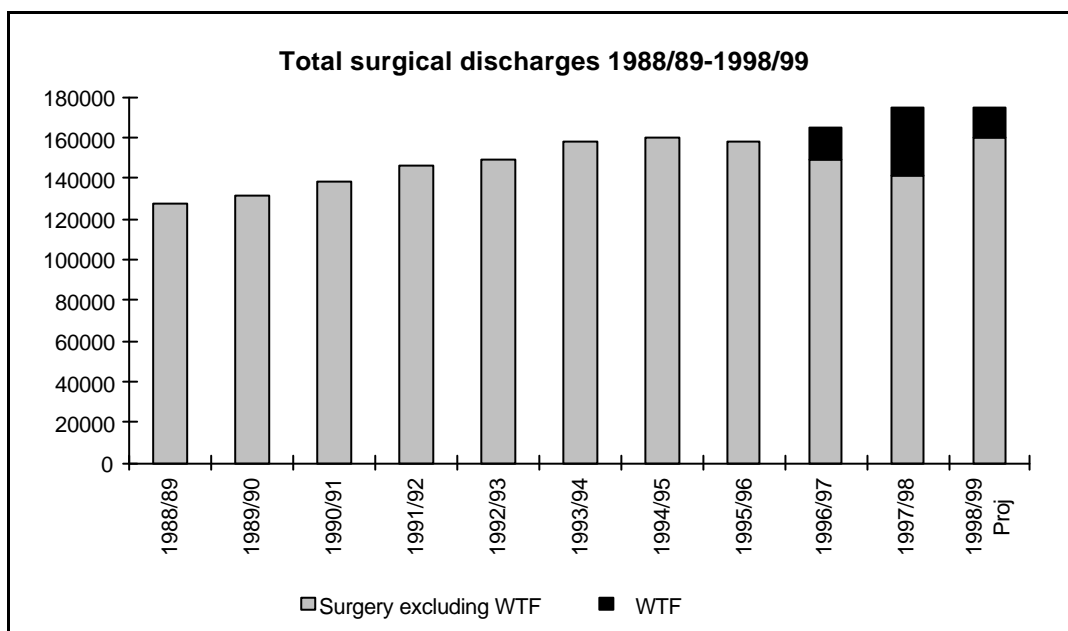
Expenditure

\$1,462.2 million was spent on medical/surgical services in 1997/98, accounting for 32 percent of Vote Health. There has been a considerable amount of additional funding injected into this area in the past few years.

Volume

Total elective surgical discharges grew from 82,000 in 1988/89 to an estimated 130,000 in 1998/99, while acute surgical discharges remained stable at around 45,000 a year over the same period. Overall, the total level of surgical discharges grew from 128,000 to 175,000 (Figure 8). There was substantial support for elective services via the Waiting Times Fund (WTF).

Figure 8: Total Surgical Discharges 1988/89-1998/99



WTF = Waiting Times Fund

Key Issues and Trends

Key issues and changes in secondary and tertiary services in recent years include:

- the development of rural health centres, rural service changes, developments in the area of telemedicine
- further development of booking systems and priority criteria for surgery
- more collaborative contracting.

Maternity Services

Maternity services include antenatal care, care during labour and birth, and postnatal care and check-ups. Maternity services are provided by GPs, midwives and specialist obstetricians.

Women have a choice as to which type of maternity provider they have and where they want to have their baby.

Women register with a chosen Lead Maternity Carer (LMC). It is the LMC's responsibility, in conjunction with the woman, to plan, provide and co-ordinate the woman's care through her pregnancy, during and after the birth.

There has been considerable change in patterns of service delivery in recent years. Midwives have been able to care for women without medical oversight since the Nurses Amendment Act 1990. This has led to increasing participation by midwives in the delivery of maternity care.

Recent data show that about 800 (61 percent) of the 1,300 LMCs who attend births are midwives and about 400 (33 percent) are GPs. This is a significant change from the previously GP-dominated service provision. Many GPs continue to provide antenatal care.

Overall, there are some 2,600 practitioners claiming as LMCs; that is, only half of all LMCs provide care at the actual birth. Of this total, about 61 percent are GPs and 35 percent are midwives.

Access in rural areas poses special difficulties of attracting and retaining practitioners, providing back-up when needed, and covering the extra costs of travel that are involved. In most rural areas there is adequate access, although women may need to travel if they want a choice of LMC. Special local arrangements have been made to ensure cover in under-resourced areas, including incentive payments and premiums on contracts.

Maternity services are required to be available to all women at no charge. This includes speciality care where deemed necessary, although if women choose the services of a private specialist they will be charged for this. GPs and midwives are required to inform women of their choices, and there is a national free-phone service, 0800 FOR A BABY, to provide information about local service providers.

Dental Health Services

Dental health services help keep the gums and teeth healthy. Dental health services for preschool, primary and intermediate school children are delivered free of charge by the school dental service which provides preventive, educative and restorative services. The school dental service is provided by the publicly owned Hospital and Health Services, with services usually delivered by dental therapists at school dental clinics.

The Government funds free dental care for teenagers aged 13-16, or up to 18 if a dependant. The Government purchases this service from private dentists. In 1996/97, 149,756 teenagers received publicly funded dental treatment.

Adult dental health services are usually provided by privately employed dentists and are paid for directly by the public; two important exceptions are specialist hospital treatment and essential dental services for low-income adults, both of which are funded by the Government.

Disability Support Services

Disability support services (DSS) are provided to people who are assessed as having a physical, psychiatric, intellectual, sensory, or age-related disability which is likely to continue for at least six months and require ongoing support. Disability support services constitute a complex and individualised range of services, from home support and residential services to information and advisory services.

Three goals form the basis of the approach to assisting people with disabilities:

- maximising independence
- effective habilitation and rehabilitation
- supporting opportunities to participate.

Having a disability is not the same as being sick, and many people with disabilities consider that many of the barriers they face to full participation and independence are located in the environment rather than due to personal impairments. Under this model support services should focus on minimising these barriers. However, for some groups of people with disabilities (notably groups with high, complex needs such as many children with disabilities and older people), there is a need for an approach which integrates medical intervention with broader social objectives and disability support.

Between 1993 and 1995 there was a major transfer of funding and responsibility for DSS from the Department of Social Welfare (DSW) to the then regional health authorities (RHAs), now the HFA, which became the primary funder of DSS.

Other government departments and agencies such as the Ministry of Education also have some responsibility to provide services for children and young people with disabilities through the Special Education 2000 initiatives. ACC provides support for people disabled as a result of an accident, and Work and Income New Zealand (WINZ) administers benefits and allowances for people with disabilities and the work test scheme.

Access to Services

The HFA purchases DSS for people with disabilities using a systematic approach (known as the DSS Framework). Before accessing services, individuals receive a needs assessment which identifies and prioritises their needs. They then access service co-ordination services which identify the most appropriate services and support options to meet their assessed needs, within available funding.

Financial Eligibility

Disability Support Services are largely funded from tax revenue, but consumers pay charges or part charges for some services. They do not pay for services such as needs assessment, service co-ordination or personal care services. DSS are free for children up to the age of 16 years or until they receive an Invalid Benefit. Access without charges to some services depends on income levels, for example, for home support.

People over 65 who have been needs assessed as requiring residential care are income- and asset-tested to determine whether a Residential Care Subsidy is required. Currently, around 27,400 older people are in long-stay care; about two-thirds of these (17,500) receive care subsidised by the HFA following an income and asset test.

Service Provision

Disability Support Services are provided by HHSs, not-for-profit providers and private sector providers. The proportion of services provided by publicly owned hospitals has declined steadily in the last decade.

The private and not-for-profit sectors provide most services for people with age-related disabilities. Historically, most community-based services for people with disabilities under the age of 65 years have been provided by not-for-profit agencies, ranging from very small providers to large providers such as IHC.

Expenditure

The HFA DSS budget is 'ringfenced', and comprises 25 percent of the total Vote Health budget. The budget for 1999/2000 is \$1.637 billion (including funding for psychiatric disability which is largely administered by the Mental Health Operating Group of the HFA).

Demand for DSS has continued at high levels since the transfers from DSW. Residential care, home support, equipment and caregiver services have all been under particular pressure. Part of this increase in demand is due to the promotion of community care options, improved services in areas such as home support, and the availability of needs assessment and service co-ordination processes. Waiting lists now exist for many services.

DSS expenditure is managed by the HFA through a variety of strategies such as setting indicative budgets for needs assessment and service co-ordination services, and targeting services.

Approximately 51 percent of HFA expenditure on DSS is on age-related disability, 16 percent on intellectual disability, 20 percent on psychiatric disability, and 13 percent on physical/sensory disability.

Mental Health Services

Access to Services

Mental health services are accessed by people with a mental illness and/or psychiatric disability. Services include crisis and acute services, forensic services, sub-acute and rehabilitation services, continuing care services, specialised services, and drug and alcohol treatment services.

Almost all clinical mental health services are provided by HHSs. Community-based residential, day care drop-in, recreational and vocational services are provided by independent service provider agencies.

Publicly funded mental health services are expected to give priority to treatment and care for the most seriously ill and for those most disabled by a mental illness. People with less serious mental illness or problems are usually treated by the generic primary health sector.

Expenditure

Concerns about mental health resulted in the 1996 Mason Inquiry into mental health services. In response to the Inquiry, the Government made additional funding available for mental health services, with the intention of supporting the implementation of the National Mental Health Strategy, and established the Mental Health Commission. Additional funding has been made available on an increasing basis over five years, in line with the objective of having an increase in annual mental health funding of \$140 million by the year 2000/01 over annual funding at the start of 1996/97. The overall aim of the funding is to increase access to mental health services.

Part 4: Nationwide Initiatives for Health

Child Health

The Child Health Strategy was launched in July 1998. It brings various initiatives in child health into a strategic framework to improve, promote and protect the health of New Zealand's children.

It promotes a set of principles and the future directions to improve the health of New Zealand children. The future directions are:

- a greater focus on health promotion, prevention and early intervention
- better co-ordination
- to develop a national child health information strategy
- child health workforce development
- to improve child health evaluation and research
- leadership in child health.

The priority population groups identified in the Strategy are:

- tamariki Māori
- Pacific children
- children with high health and disability support needs
- children from families with multiple social and economic disadvantages.

Focus is now on implementation of the Strategy.

An additional \$13.25 million has been allocated annually towards improving the health of children in the four priority population groups. The additional services will assist in implementing the future directions identified in the Strategy. The funds are being spent to provide extra home-based health services to priority groups and extra school-based health services in schools in lower socio-economic areas, to increase dental services for preschool children, and to provide some extra disability support services.

Māori Health

Measures of the status of Māori health all indicate that Māori experience an excess burden of mortality and morbidity. The relatively poor health status of Māori result from the following interrelated factors:

- poorer social and economic status of Māori
- health services failing to reach Māori to the extent indicated by their high health needs
- greater exposure to behavioural/lifestyle and physiological risk factors.

Māori Provider Development Scheme

The Māori Provider Development Scheme (MPDS) was implemented in December 1997. Funding categories include:

- Provider Assistance
- Workforce and Service Development
- Best Practice and Procedure Models
- Māori Health Scholarships.

The two priority areas for the MPDS are:

Māori health and disability service development, which aims to enable Māori health providers to develop more effective health and disability service provision.

Māori health and disability workforce development, which aims to accelerate and improve the Māori health and disability workforce.

The number of independent Māori providers delivering health services targeted to Māori increased from around 23 in 1993 to over 240 in 1998.

Pacific Health

The health status of Pacific people in New Zealand lies between that of Māori and the total population. The poor health status of Pacific people can be related to lower socioeconomic status, the ability to gain employment, and the changes in traditional Pacific support structures that are often associated with adjustments to a New Zealand way of life.

Pacific health service provision has developed over the past five years. The current amount spent on specific Pacific health service providers is between \$10 million and \$12 million. The majority of services are located in the Auckland region, although services are provided around the country. The major areas of service delivery are health education, health promotion, primary care (GP services), screening services and specialist services that require a high level of interpersonal contact, such as drug and alcohol treatment or sexual health services.

The Ministry of Health recently produced a policy framework *Making a Difference in Pacific Health Policy* (Ministry of Health 1998), which identifies the priority areas for policy development:

- strategic policy advice
- monitoring funder performance
- leadership and strengthening relationships
- health sector financing
- Ministry of Health structure and culture

- relationships with Māori.

New initiatives include:

- **Child Health Strategy:** \$2 million has been allocated to improve well child, immunisation and primary care service delivery to Pacific children and families.
- **Family Start:** the HFA has funded the Ranui-Massey site of Family Start to ensure that sufficient Pacific people are involved in the pilot.
- **Pacific Provider Development Scheme:** this scheme was developed in recognition of the importance of increasing the capacity and ability of Pacific peoples to provide effective services to the community. The scheme has been allocated \$1.2 million, and provides opportunities for Pacific health providers to enhance their business skills and to ensure that they are better placed to fully participate in the development of the health sector in the future.

Mental Health Strategy

The National Mental Health Strategy *Looking Forward* was launched in 1994. This was followed in 1997 by *Moving Forward*, the national implementation plan, which set out targets and responsibilities for the central agencies.

The Mental Health Commission is charged in statute with responsibility for ensuring implementation of the strategy.

The strategy has two goals:

- to decrease the prevalence of mental illness and mental health problems within the community
- to increase the health status of, and to reduce the impact of mental disorders on, consumers, their families, caregivers and the general community.

The strategy focuses on access to services for the most severely ill (estimated to be 3 percent of the population). The key directions of the National Mental Health Strategy are:

- more mental health services
- more and better services for Māori
- better services
- balancing personal rights with protection of the public
- developing and implementing a national drug policy
- developing the mental health services infrastructure
- health promotion and illness prevention.

Initiatives since 1997 have included:

- specific policies in the areas of youth suicide, alcohol and drug dependence, child and youth services
- freeing up access to atypical anti-psychotic drugs

- better access for GPs to prescribe newer antidepressant medication
- making progress towards a national mental health information database
- the development of National Mental Health Standards, cultural assessment tools and risk-assessment tools
- the production of best practice guidelines for the treatment of depression, anxiety and alcohol and drug dependence in primary care by the National Health Committee on Health and Disability
- *Like Minds, Like Mine*: the national project to counter discrimination and stigma
- a significant increase in services and in the proportion of the HFA budget committed to secondary and tertiary mental health services (from 7 percent in 1993/94 up to 10 percent in 1998/9).

Youth Suicide Prevention Strategy

New Zealand has one of the highest rates of youth suicide in international comparison, and it is particularly high for Māori.

The New Zealand Youth Suicide Prevention Strategy was launched in March 1998, and provides a multi-sectoral approach to this issue. The Strategy, which is being led by the Ministry of Health, takes a broad-based and co-ordinated approach to suicide prevention - health promotion, early identification, treatment, post-crisis support and research. There are two separate but inter-connecting components: *In Our Hands* which is the general population strategy; and *Kia Piki te Ora o te Taitamariki* which has been developed for Māori.

Strengthening Families

Strengthening Families is a strategy that aims to improve life outcomes for children in families at risk. It is supported by the Health, Education and Welfare sectors and many other agencies involved in, or associated with, providing social services.

Families at risk are defined as 'families who are experiencing multiple and persistent disadvantages which compromise family functioning and increase the chances that their children will have poor long-term outcomes'. It is estimated that around 5 percent of New Zealand families are trapped in a cycle of disadvantage, and up to a further 45 percent of families could be at risk of becoming caught in a disadvantage cycle.

The Strengthening Families strategy comprises two work streams:

- Stream 1: Improved services through local level co-ordination and collaboration
- Stream 2: Improved social services through central co-ordination of policy, funding and purchasing.

Stream 1: Improved services through local level co-ordination and collaboration

Local level co-ordination aims to improve local services to at-risk families through improved social service collaboration. This is achieved through inter-agency case management, identifying gaps and overlaps in services and joint initiatives to use resources more effectively. A range of government agencies and community groups are represented on local co-ordination groups.

There are now 59 local management groups operating across the country, with five steering groups overseeing clusters of groups in Northland, North Shore, Auckland, South Auckland and Manawatu. Most localities are using the inter-agency case management approach. Some common barriers to its use have been identified and are being worked through by a project team. Facilitation skills training is being delivered across the country.

New Preventive Aspect to Strengthening Families

The Strengthening Families strategy has moved into higher gear in three priority areas: Northland, Porirua/Hutt Valley and East Cape. This initiative is also being extended to include the following regions: Christchurch, Rotorua, Invercargill, Dunedin, Whakatane/Kawerau/Opotiki, Hastings/Napier, Horowhenua, Waikato, New Plymouth, Manukau, Papakura, Auckland, Whanganui, Palmerston North, Masterton, Nelson, Taupo, Kapiti Coast, Western Bay of Plenty, Timaru, Waitakere and South Taranaki. Social service workers in these areas will work in a concerted effort to focus services on children who are at higher risk of experiencing health, education and welfare problems. The aim is to concentrate on four key aspects of social services in these regions:

- promoting participation in early childhood education services
- promoting better use of primary health and dental care
- making information available which promotes immunisation
- promoting successful participation in schools.

The initial focus is on primary school children indefinitely suspended from school, children with parents in prison, children of teenage parents and children from families who have been reliant on the domestic purposes benefit as their main income for 10 years or more.

Stream 2: Improved social services through central co-ordination of policy, funding and purchasing

Family Start

In December 1997, Cabinet agreed to establish Targeted Family Service prototypes (Family Start). These prototypes have the following key features:

- systematic identification of high-risk families

- accurate assessment of family needs
- family workers delivering family-focused services in the home
- co-ordinated access to appropriate mainstream or specialist services
- services provided as early as possible in the child's life.

Since Family Start services began in early December 1998, over 120 families have been accepted into the programme in the initial Whangarei, Rotorua and Ranui-Massey prototype sites.

Social Workers in Schools Programme

Funding has been set aside by the Department of Child, Youth and Family Services to introduce and evaluate a two-year pilot 'Social Workers in Schools' programme in the three geographical areas of Tai Tokerau/Northland, Tai Rawhiti/East Coast and Porirua City/Hutt City.

Services are targeted predominantly to primary schools and communities with:

- high levels of social need
- high proportions of Māori and/or Pacific students
- a demonstrated commitment to actively supporting the programme.

Improving Child and Youth Mental Health Outcomes

A number of child and youth mental health projects are under way, and report to the Minister of Social Services, Work and Income:

- an information booklet (*Tough Times*) to help educate workers in the health, education and welfare sectors about child and youth mental health issues. The booklet is being distributed through the local co-ordination networks.
- development of training opportunities for health, education and welfare workers in identifying problems early and responding appropriately
- identification of innovative, effective interventions to assist children and young people with mild to moderate mental health problems with a view to expanding any such existing programmes.

Immunisation

Immunisation has contributed significantly to the control of a number of important infectious diseases in New Zealand, including polio, diphtheria, tetanus, *Haemophilus influenzae* type b (Hib) disease, congenital rubella, and hepatitis B. Other vaccine- preventable diseases continue to be public health problems (for example, pertussis and measles).

The Immunisation Schedule protects children against nine serious diseases: diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, hepatitis B and Hib. For full protection, parents must take their child to the vaccinator four times in the first 15 months, and once at 11 years (although the 11 year-old vaccination is usually given at school).

Immunisation 2000 is the national immunisation strategy launched in 1996. The aim is for at least 95 percent of New Zealand children aged two years to be fully immunised by the year 2000. The revised policy is to increase the likelihood that children would complete the course of early childhood immunisations, and reduce the likelihood and extent of outbreaks of vaccine-preventable disease in Early Childhood Centres and primary schools.

While over 95 percent of children receive their first immunisation at six weeks of age, about 40 percent fail to complete the full series. Immunisation coverage levels in 1996 showed that, at best, a plateau had been reached, and that further impetus would be required if the 1997 target of 85 percent, and the year 2000 target of 95 percent, are to be reached for all vaccines. Immunisation coverage rates need to be sustained at 95 percent to effectively control and eventually eradicate vaccine-preventable diseases.

North Health's *1996 Immunisation Coverage Survey* showed an increase in all children being fully immunised at age two, from 55.4 to 63.1 percent. However, there were marked disparities between the ethnic groups in the region: for Māori children the coverage rate was only 44.6 percent and for Pacific children 53.1 percent, compared with 72.3 percent for all other children.

Coverage has also been estimated based on immunisation benefit claims data. This showed a decline in 1997 for the first time, after continuing small increases since 1994. The data for 1998 are not yet available, but the data for the first three-quarters suggest an important decline, especially for measles-mumps-rubella (MMR) vaccine. This may be related to adverse publicity on alleged links between MMR and autism and Crohn's disease. The continuing lack of reliable immunisation information and a system to follow up those missing out are the major problems of the immunisation programme. Although New Zealand has an active anti-immunisation lobby, surveys have shown that opposition to immunisation is not the reason for low coverage rates. Less than 5 percent of parents are opposed to immunisation.

National Breast Cancer Screening Programme

In June 1995 the Government agreed to establish a national breast cancer screening programme (NBCSP) to be implemented over the following three years, because:

- breast cancer is the leading cause of cancer deaths for non-Māori women in New Zealand, and the second leading cause for Māori women, after lung cancer
- there was strong international evidence of the efficacy of breast screening in reducing mortality among women aged over 50 years if screened on a regular two-yearly basis
- studies showed that breast cancer screening is value for money relative to other health interventions
- results of two pilot programmes in Otago and Waikato demonstrated that screening can be done effectively and efficiently in New Zealand.

The aim of the NBCSP is to detect breast cancer early, when it is potentially treatable. Breast cancer cannot be prevented. Delivered through a properly organised population-based screening programme, international evidence shows that screening can reduce mortality from breast cancer for women aged 50-64 years by approximately 30 percent.

Two-thirds of women who develop breast cancer in New Zealand are over the age of 50. In 1994, nearly 600 women aged 50-64 were newly registered with breast cancer, and 172 died.

The NBCSP policy is for free two-yearly breast screening for well women aged 50-64 years. Access to publicly funded mammograms is also available to all women with symptoms of breast cancer, women who have breast cancer, and women aged 40-49 years who have either a strong family history of breast cancer (mother or sister) or a diagnosed breast at-risk lesion.

Hepatitis B Screening Programme

Hepatitis B is a viral disease, usually transmitted by infected blood or sexual activity. In New Zealand, most transmissions occur between children in the school environment. During pregnancy and birth, transmission from mother to infant also occurs. In New Zealand the disease is common in Asian, Pacific and Māori people. Hepatitis B can cause an acute illness and liver damage. Infection can also result in a carrier status without overt disease, with later development of cancer of the liver or severe liver damage.

Vaccination is offered to all children (as part of the Immunisation Schedule) since 1988, and there is antenatal screening of mothers and additional immunisation for babies of carriers. There is also routine screening for blood donors, and hepatitis B vaccination is offered to sexual partners, household and family contacts of all identified carriers of hepatitis B.

As universal childhood immunisation was only introduced relatively recently, there is a pool of people at high risk who are not immunised. Furthermore, child immunisation coverage is not complete as many Māori and Pacific children are not completing the three-dose immunisation course.

A screening programme was proposed to identify those who may be hepatitis B carriers, as well as those who are not immunised but may be at risk of contracting the disease. Identification and follow-up of carriers will allow early treatment when disease develops. The programme will also provide an opportunity to immunise those identified as at risk who are not yet immunised.

The programmes will include a 'one-off' immunisation of those at risk and identification of all carriers of hepatitis B, with ongoing follow up and treatment when required. The programme will be targeted at Māori, Pacific and Asian populations in North Island areas with the greatest prevalence of infection.

Cervical Screening

A recent case of cervical cancer following misreading of regular slides has raised concerns about cytopathology practice. Although the case was brought to public attention through a High Court action, the period in which the pathologist concerned practised was 1967-96. Since that time, all

community laboratories contracted by the HFA to carry out cytopathology have had to be accredited. Quality control and quality assurance programmes have also been introduced, the latter with input from the Royal College of Pathologists of Australasia.

The HFA is addressing concerns for the safety and assurance of other women in the area whose slides may have been misread. Actions include:

- free screening for women in Gisborne due and overdue for their regular smear test. This extends to women who may have moved to other areas but whose last smear was in Gisborne
- an 0800 line for information
- a review of all slides read by the pathologist between 1990 and 1996.

The HFA has set up a specialist advisory group to advise on the situation in Gisborne and to set priorities for effective measures to minimise harm to other women. The Ministry of Health is investigating the wider issue of whether patients are adequately protected under existing occupational laws when their doctor has been found to have acted incompetently or unsuitably.

Regular cervical smears are still the best means of prevention of cervical cancer. Since the National Cervical Screening Programme was started in 1990, deaths from cervical cancer have reduced by almost a third.

National Drug Policy

The National Drug Policy was released in July 1998. It is based on a principle of harm minimisation, seeking to reduce the harm caused to individuals and society by the use of tobacco, alcohol, and illicit and other drugs. Tobacco and alcohol are the drugs that cause by far the greatest harm in New Zealand. A wide range of initiatives is in place to reduce this harm.

In August 1998 the Ministerial Committee on Drug Policy identified two areas of concern that Ministers wanted to see addressed:

- the cannabis problem in the Far North and the East Coast of the North Island
- preventing the expansion of a hard drugs market in New Zealand.

A work programme on illicit drugs was released in March 1999. The work programme outlines initiatives that have been, or are being, implemented in five areas:

- information, research and evaluation
- health promotion
- treatment services
- law enforcement
- policy development.

Two initiatives which have sparked considerable media interest and comment lately are:

- reviewing the classification of controlled substances, with a view to reclassifying Ecstasy as a Class A drug
- the level of funding for alcohol and drug treatment services, particularly for young people and people in correctional facilities.

Hospital Services Plan

The Hospital Services Plan was released by the Government in September 1998. The main message of the Hospital Services Plan was a commitment by the Government to maintaining the current distribution of services for three years. It stated that the Government was open to using alternative providers and facilities if that improves access, efficiency and quality of services. It also pointed out that although change is inevitable, from now on it will be evolutionary in nature, and changes will most likely originate from the local perception of local needs.

The Hospital Services Plan is underpinned by five main objectives:

- timely access to hospitals
- safe, quality hospital services
- fairness across the country
- value for money
- acknowledging the special needs of rural and provincial communities.

The Hospital Services Plan framework ranks hospitals into five categories according to the complexity of the procedures carried out and the type of emergency care they provide. The five categories are:

1. *Health Centre*

These vary considerably in size and scope, but most offer primary and community health services and may have inpatient beds for continuing care or low-risk births.

2. *Sub acute units*

These provide inpatient medical beds and day surgery.

3. *Secondary hospitals*

These are equipped to cater for most of the local population's needs and to offer 24-hour secondary services. Most provide general medicine and general surgery, paediatrics, maternity, orthopaedics, gynaecology, ENT, ophthalmology and urology.

4. *Lower level tertiary hospitals*

These provide the services of a secondary hospital as well as a greater number of sub-specialities, such as oncology and regional public health units.

5. *Higher level tertiary hospitals*

These usually have neurosurgery, burns/plastics, spinal, bone marrow, cardiothoracic, adult liver transplants, renal transplants, the most specialised neonatal units and forensic mental health services.

Roadside to Bedside – Acute Management System

Roadside to Bedside, a document released in March 1999, articulates the key principles and characteristics of a 24-hour clinically integrated acute management system. The publication was developed and endorsed by the Ministry of Health, the HFA, the ACC and the Council of Medical Colleges in New Zealand.

Its key aim is ‘that people should get the right care, at the right time, in the right place from the right person’. The critical features of the system are:

- the establishment of five regional networks involving all people or organisations associated with pre-hospital care or emergency transport and all hospitals
- the delivery of patients to the nearest hospital capable of providing definitive care, or local management if that is most appropriate
- the integration of all services involved in the management of acute health needs
- an appropriate emergency transport system
- safe practice guided by agreed guidelines, protocols and standards
- workforce development
- access to telecommunications and emergency response.

The HFA is leading the three-year implementation of the system, assisted by a national advisory committee that has been established to oversee the whole implementation process. Members of this committee include a trauma specialist, an emergency medicine specialist, an emergency nurse specialising in paediatrics, a rural GP, a representative of the New Zealand Ambulance Board, and officials. The first two networks are being established in the Northern and Midland areas. Network teams, based on the current trauma committees, are being established and their terms of reference developed. The remaining three networks will be developed by 1 July 2000. Clinical focus groups are also being established to review or develop guidelines and standards for each area of clinical practice. The first three groups are currently being established and will focus on trauma, obstetric care, and pre-hospital and rural emergencies.

Healthline

The Government has recently announced the development of a telephone triage and health advice line pilot. The pilot line, currently known as *Healthline*, will be trialled for two years in Northland, the North Island's East Coast, the South Island's West Coast and in Canterbury. It will be modelled on successful telephone triage systems around the world, such as ‘NHS Direct’ in Britain and ‘Health Direct’ in Western Australia.

Healthline will be free and available 24 hours a day, 365 days a year. It will provide:

- triage advice, which includes an assessment of a patient's condition and then, if necessary, direction to the most appropriate level of treatment and the timeframe within which this should occur
- advice on self-care and symptom management, if appropriate
- advice on the prevention of illness
- health information, for example, information about diseases or pharmaceuticals
- information about the availability and location of services
- referral or connection to other emergency services (ambulance, poisons information, hospital accident and emergency department, mental health crisis teams etc)
- call-back to check progress as agreed.

Callers will seek health and emergency advice and have their condition assessed by a health professional backed up by sophisticated computer-based information. In other countries, these systems have proved both popular and successful in ensuring people get the right care at the right time by the right people.

The service is to be independently evaluated through a Ministry of Health contract. Key objectives of the evaluation include:

1. the establishment of *Healthline* and the lessons to be learnt from this
2. the utilisation of *Healthline* by different population groups
3. the health outcomes of the advice provided by *Healthline* staff
4. the effect of *Healthline* on the utilisation of other services such as accident and emergency departments and GPs
5. consumer satisfaction with the scheme
6. health care provider satisfaction with the scheme
7. cost-effectiveness of the scheme.

Part 5: Funding and Expenditure

International Comparisons

International evidence is that:

- demand for health services grows continuously
- in general, expenditure on health services grows faster than GDP. While there is no optimal level of health care spending relative to GDP, the relationship between them is well established. Typically, as GDP per capita increases, health expenditure grows by 1-1.5 times the rate of GDP.

New Zealand currently spends around the amount on health that would be expected of a country at its level of GDP. Vote Health is currently \$6,686 million (1999/00)

Trends in Expenditure

- Over time, spending on health in New Zealand has grown see Figure 9(a) and Figure 9(b).

Figure 9(a): Aggregate Real (\$1997/98) Health Expenditure

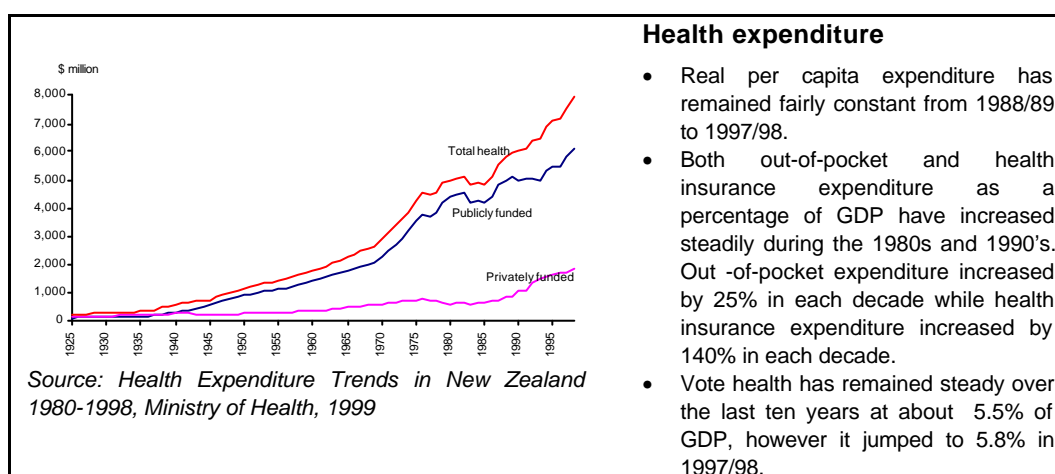
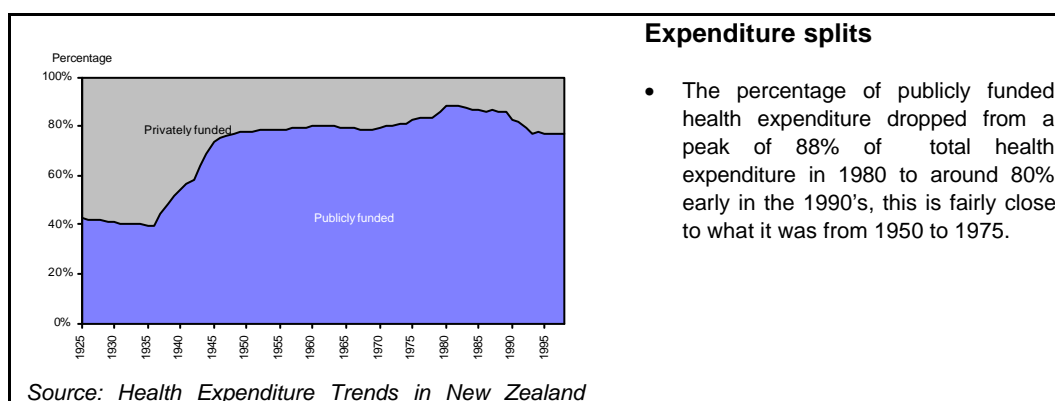


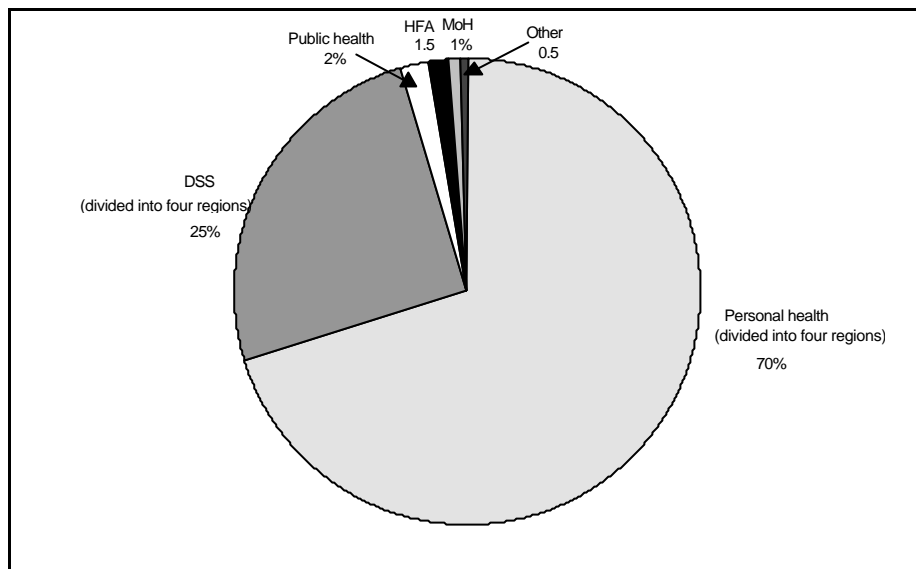
Figure 9(b): Publicly and Privately Funded Expenditure Shares



Public Expenditure

A breakdown of the main expenditure categories in Vote Health is provided in Figure 10.

Figure 10: Vote Health 1999/00 by appropriation



The bulk of Vote Health - 97 percent - is funding for the HFA to purchase health and disability services. This funding is divided into appropriations according to type of service, namely:

- **Personal Health** (\$4,621 million in 1999/00), which is used to purchase hospital-based health services as well as community-based services like GP consultations, midwifery services and pharmaceuticals.
- **Disability Support Services** (\$1,637 million in 1999/00), which is used to purchase services for people with disabilities. Responsibility for purchasing these services was progressively transferred from Social Welfare from 1993/94.
- **Public Health Services Purchasing** (\$121 million in 1999/00), which is used to purchase services for specific population groups or for the population as a whole.

The remaining 3 percent of Vote Health is made up of funding for HFA administration (\$105 million in 1999/00), the Ministry of Health (\$56 million in 1999/00) and a number of other organisations and providers (totalling \$32 million in 1999/00). These latter organisations include the Health and Disability Commissioner, the Mental Health Commission and New Zealand's contribution to the World Health Organization.

Personal Health and DSS are further appropriated to four separate geographical regions, defined by the previous Regional Health Authority (RHA) boundaries:

- **Northern** (Auckland and Northland)
- **Midland** (Waikato, south to the East Cape and Taranaki)
- **Central** (the remainder of the North Island, Nelson-Marlborough)

- **Southern** (the remainder of the South Island).

Public Health Services purchasing is not formally appropriated to the four regions but is still divided between them. A small portion of public health funding is also administered by the Ministry of Health.

Funding is divided between these four regional ringfences according to the population-based funding formula (PBFF). In fact there are three PBFFs - one for each of Personal Health, DSS and Public Health. These PBFFs divide up funding according to the number of people living in each region (hence 'population-based' funding) but also take into account various characteristics of the regional populations which affect their need for health and disability services, such as ethnicity and age structure.

Health Insurance

Health insurers in New Zealand insure people for some or all of the gap between the government subsidy on a range of health services and the charges levied by health service providers. Insurers also provide supplementary insurance, which reimburses consumers for surgery and other interventions for which they might have to wait in the public health care system.

Part 6: Legislation

Legislation administered within the health and disability sector is the responsibility of a range of agencies, including the Ministry of Health, Hospital Health Services, local government, occupational licensing bodies and the Health and Disability Commissioner.

Legislation within the health and disability sector falls into three groups:

- structural
- consumer protection
- public health.

The legislation related to each of these groups is described in turn below.

Structural Legislation

The Health and Disability Services Act 1993 and subsequent amendments:

- established the HFA and HHSs, and their objectives and functions
- enables the Minister of Health to enter into a Funding Agreement with the HFA
- enables the HFA to enter into purchase agreements with providers of health and disability support services
- established the National Advisory Committee on Health and Disability
- established the National Advisory Committee on Health and Disability Services Ethics.

Section 14 provides that the HFA and HHSs are Crown entities for the purposes of the Public Finance Act 1989. The HFA and the HHSs are therefore required to comply with the reporting requirements of that Act. In particular, they must prepare Statements of Intent, annual financial statements, and annual reports in accordance with the Act.

The Health Research Council Act 1990 established the Health Research Council as a purchaser of health research.

Some structural elements are included in other legislation, such as the Blood Transfusion Trust under the Health Act 1956.

Consumer Protection Legislation

A range of legislation has the aim of protecting consumers of health and disability support services, through regulating health professionals, therapeutic products, health and disability support service premises, and consumer rights.

Health and Disability Occupations

Every professional group that carries out procedures considered to be potentially harmful to the patient is regulated with regard to professional registration and disciplinary procedures. (Some groups, such as naturopaths, where the risk is considered low, are not regulated.) Each recognised health professional group has its own board or council.

Registration boards or councils set standards of competence and approve education programmes that meet the standards. They monitor educational providers and educational standards of students by examination (in some instances set by the registration board) or formal approval/accreditation processes. The boards and councils also discipline members where appropriate.

Safety of Health-care and Therapeutic Products

The Medicines Act 1981 requires medicines and medical devices to be regulated. The Ministry of Health is developing proposals to replace the Medicines Act with new legislation which will include the regulation of dietary supplements.

The Radiation Protection Act 1965 provides a safety regime for the use of irradiating apparatus (for example, x-ray machines and radioactive materials such as those used to sterilise medical equipment). The National Radiation Laboratory (a business unit of the Ministry of Health) licenses the users of radioactive materials and irradiating apparatus.

Health and Disability Facilities

The Hospitals Act 1957 (and Hospital Regulations 1993) provide for the licensing of all hospitals. It states the requirements that hospitals must meet before being licensed to operate.

Rest homes are licensed through the Old People's Homes Regulations 1987 (made under the Health Act 1956) and homes for people with disabilities are registered through the Disabled Persons Community Welfare Act 1975. The Ministry of Health carries out these procedures.

The facilities used by other community- or home-based services are subject only to general legislation such as the Building Act 1991.

The Health and Disability Services (Safety) Bill, currently awaiting its third reading, proposes to revoke the licensing and registration regime and replace it with a standards-based safety regime.

Consumer Rights and Complaints

The Health and Disability Commissioner, under the Health and Disability Commissioner Act 1994, is responsible for promoting and protecting the rights of health and disability consumers, and to that end facilitating the fair, simple, speedy and efficient resolution of complaints relating to infringements

of those rights. See Part 2 of this volume for more details on the Health and Disability Commissioner's role. The Health and Disability Commissioner recently completed a review of the Health and Disability Commissioner Act. A copy of her report was tabled in the House on 5 October 1999.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 provides for the compulsory assessment and treatment of people who are considered to be 'mentally disordered' within the meaning of the Act. The Minister may direct the Director of Mental Health in certain duties under the Act including: to carry out an inquiry, to visit a service, and investigate matters pertaining to mental health.

Ethical review of research and new treatments or technologies is carried out by Ethics Committees. There are 14 local committees, along with the Health Research Council's Ethics Committee and the National Ethics Committee on Assisted Human Reproduction. These committees work in complementary ways.

Public Health Legislation

Public health legislation is designed to prevent harm to individuals and communities from communicable disease, environmental risks via water and sewage, and risks to health from consumption of products such as food, alcohol or tobacco.

Designated officers such as Medical Officers of Health, Health Protection Officers and Smoke-free Officers, are employed by HHSs and act under the statutory authority of the Director-General of Health to enforce public health legislation. Local authorities also have public health regulatory responsibilities, and employ Environmental Health Officers to enforce by-laws and carry out the public health functions for which they are responsible. The Ministry of Health provides some public health regulatory services, especially around food and tobacco, and purchases science services to support the range of public health regulatory activities.

Health Act

The Health Act 1956 is the major statute controlling risks from communicable disease (including quarantine). It establishes a progressive set of powers, which range from requirements for all doctors to notify cases of certain infectious diseases, through to the extremes of compulsory isolation or examination, destruction of property or animals, closure of schools, theatres and other public places, and commandeering premises to be used as isolation hospitals. These emergency powers can be exercised if a civil emergency has been declared or on Ministerial authority. The Director-General of Health designates Medical Officers of Health and Health Protection Officers to carry out these functions.

The Act establishes the responsibility of local government to improve, promote and protect health in their areas, including specific provisions for sanitary works in relation to water and sewage disposal. There are anomalies and overlaps between the Health Act and the Resource Management Act.

The Health Act also confers limited powers and responsibilities concerning non-communicable diseases, provides for regulation of the blood transfusion services, compulsory care of the frail elderly, and for cervical screening registers. It establishes the role of a Director of Public Health and a Public Health Group within the Ministry of Health, which is to consult, report and advise on the state of the public health and public health issues tabled annually in Parliament. It requires that a report on the state of the public health be submitted to the Minister of Health annually.

Food Act

The Food Act 1981 allows standards to be set and enforced for food manufacturers and food premises. The Act was substantially amended in 1996 to:

- streamline the system for developing and setting food standards within the New Zealand system and recognise standards developed within a new joint system between Australia and New Zealand for setting food standards
- give legal recognition to industry-based food safety programmes, and encourage a voluntary transition by the food industry from the prescriptive requirements of the Food Hygiene Regulations 1974 to food safety programmes based on the internationally recognised Hazard Analysis Critical Control Point (HACCP) system.

Smoke-free Environments Act

The Smoke-free Environments Act 1990 aims to reduce the exposure of people who do not smoke themselves to any detrimental effect on their health caused by others' smoking. It also regulates the labelling, advertising, promotion and availability of tobacco products, and monitors and regulates the presence of harmful constituents in tobacco products and tobacco smoke. An amendment to the Act is currently before Parliament.

Other Public Health Legislation

The Ministry of Health administers a number of other statutes which contribute to improving, promoting and protecting the public health. They give powers and responsibilities to collect information, set standards and control hazards.

Many important statutes regulating health and safety risks are administered outside the health and disability sector. Some, including the Hazardous Substances and New Organisms Act 1996 and the Biosecurity Act 1993, are implemented and enforced by designated officers within the health sector, but others are the direct responsibility of other sectors - these include the Resource Management Act 1991, the Fire Service Act 1975, the Building Act 1991, the Meat Act 1981 and the Dairy Industry Act 1952, as well as transport and safety legislation and general legislation around consumer goods and regulation of transport safety and consumer goods.

Part 7: Health Information

In an international context, New Zealand is seen as one of the leaders in developing and using health information. The National Health Index, the extent of electronic claiming, and the general level of information technology penetration in health services are some of the facets which put New Zealand in advance of many health systems.

National systems operated by the New Zealand Health Information Service are outlined below. Other national databases include:

- Health Benefits Limited: information on utilisation rates for GP consultations, pharmaceuticals, laboratory, maternity and other personal health services
- CCMAU: aggregate performance data on public hospitals.

New Zealand Health Information Service (NZHIS)

The New Zealand Health Information Service (NZHIS) is a business unit of the Ministry of Health and has responsibility for:

- collecting, processing, maintaining, and disseminating health data, health statistics and health information
- maintaining and developing national health and disability information systems
- developing and providing health and disability information standards and quality audit programmes for data.

The three major databases supported by the NZHIS are the National Health Index, the Medical Warning System, and the National Minimum Data Set.

National Health Index

The National Health Index (NHI) provides a mechanism to uniquely identify health care consumers. It was developed in part to help protect personally identifying health data, particularly those that are held on computer systems.

The use of the NHI's national unique identifier, together with an electronic key, restricts access to authorised key holders only and is permitted by the Health Information Privacy Code 1994 made pursuant to the Privacy Act 1993. The use of the NHI ensures that when health information is communicated from point to point in the health and disability sector, easily recognisable identifying details such as name and address can be removed.

Medical Warning System

The Medical Warning System (MWS) is designed to warn health care providers of the presence of any known risk factors that may be important in making clinical decisions about individual patient care. Responsibility for maintaining the content of the MWS rests primarily with its users - the health care providers. Access to MWS features depends on the provision of a valid unique identifier of the health care consumer.

The MWS comprises:

- medical warnings incorporating adverse medical reactions and significant medical conditions
- event summaries incorporating identification of the facility where a patient/consumer's medical record is located
- donor information.

National Minimum Data Set

The National Minimum Data Set (NMDS) is a collection of health data, developed in consultation with health sector representatives, required at national level for:

- policy formulation
- monitoring and evaluation of policy implementation
- performance monitoring and evaluation
- health status measurement
- meeting international reporting requirements.

To ensure health event data provided to the NMDS are made anonymous, each record is identified with the health care consumer's NHI number in encrypted form only. No personally identifying information is kept nationally.

The types of data available from the NMDS are as follows.

Inpatients and daypatients discharged from publicly funded hospitals

Data about all daypatients and inpatients discharged from hospital are supplied directly to the NMDS by hospital-based computer systems. They include information on diagnoses, diagnostic and therapeutic procedures, as well as demographic information about the patient/consumer (for example, ethnicity, age, sex, domicile).

Inpatients and daypatients discharged from private hospitals

The data currently collected include principal diagnosis, diagnostic or therapeutic procedure, as well as demographic information about the patient/consumer (for example, age, gender, domicile).

Cancer Data (New Zealand Cancer Registry)

The New Zealand Cancer Registry collects and interprets data on individuals with cancer. It can provide information that is useful in identifying the causes of cancer, in designing and monitoring prevention and screening programmes, in monitoring the results of treatment (survival studies), and in planning for cancer services.

The Cancer Registry Act 1993 requires that persons in charge of laboratories report all diagnoses of primary malignant disease. The New Zealand Cancer Registry has operated since 1948 and currently registers approximately 13,000 new primary tumours each year. It is a population-based tumour register of all primary malignant disease, except basal-cell and other 'simple' skin cancers.

Mortality Data

Data on cause of death are based on the legal death certificate or coroner's report together with autopsy reports when available. The data include underlying cause of death, and demographic information about the deceased (for example, ethnicity, age, sex, domicile).

Standards for Health Information

The Ministry of Health facilitates the development of national standards and protocols for health data definition and data exchange.

The Privacy Commissioner has released a code of practice - the Health Information Privacy Code 1994 - under the Privacy Act, which provides a standard for protecting the privacy of individual consumers.

Part 8: International Linkages

The Government and Ministry of Health have a number of international relationships and responsibilities. There are three main types of formal activity:

- joint activities with Australia
- participation in major multilateral agencies such as the World Health Organization, the South Pacific Commission and the OECD
- obligations under major international covenants or agreements on health.

Joint Activities with Australia

New Zealand has extensive and increasingly important health links with Australia.

- **Ministerial:** the New Zealand Minister of Health is a member of the Australian Health Ministers' Advisory Council, which meets formally twice a year.
- **Joint access to health care:** A reciprocal health agreement gives New Zealanders access to Australian health services and vice versa for immediately necessary care through the Health Benefits (Reciprocity with Australia) Act 1986.
- **Harmonisation of regulations:** under the Trans Tasman Mutual Recognition Agreement (TTMRA), Australia and New Zealand are progressively standardising their health regulations. Areas where harmonisation or mutual recognition is under way include safety standards, food standards, therapeutic devices, medicines and health occupations.
- **A joint Australian-New Zealand Food Authority (ANZFA):** was established in July 1996. New Zealand involvement in ANZFA is expressed in the Agreement between the Government of New Zealand and the Government of Australia establishing a system for the development of joint food standards. ANZFA generates the food standards, which are approved by a Ministerial Council comprising Health Ministers of the Australian Commonwealth States and Territories and New Zealand. New Zealand has one vote. Once so approved, the food standards are adopted into domestic legislation by New Zealand. Safety and labelling of genetically modified food is dealt with under this process.

World Health Organization (WHO)

New Zealand is a founding member of the United Nations' World Health Organization (WHO), contributing approximately \$NZ1.5 million to its budget every two years. Under the WHO constitution, member governments must take responsibility for the health of their peoples and must provide adequate health and social measures to achieve this.

New Zealand belongs to the Western Pacific Regional Committee, and attends its meeting each September. It also provides a delegation of Ministers and officials to the annual World Health Assembly in Geneva each May.

New Zealand is actively involved in a review of the WHO Constitution as part of WHO reform.

The Government is also party to a number of WHO agreements. Key agreements which the Government has committed New Zealand to implementing include:

- *Alma Ata Health Declaration*, which affirms that people have a right and duty to participate individually and collectively in the planning and implementation of health care, and defines minimum criteria for what constitutes primary health care
- *Ottawa Charter of Health Promotion*, which advocates a clear political commitment to health and equity, and sets out to focus attention on public health issues, and have the voice of the community accepted as essential in health
- *WHO Code on Marketing of Breast Milk Substitutes*
- *WHO International Health Regulations*.

These agreements are administered by the Ministry of Foreign Affairs and Trade.

WHO is currently developing a Framework Convention on Tobacco Control, and New Zealand is actively participating in this work.

PART 9: The Ministry of Health

Ministry Vision

*Facilitate the development of the health and disability sector to maximise the potential of people with disabilities and the health of New Zealand people – ‘**Healthy New Zealanders**’.*

Ministry Mission

*An effective facilitator of desired change, actively linked with and understanding the total health and disability sector - ‘**Leading Health**’.*

Ministry Values

*Highly professional
Internally consistent
Totally coherent*

Role of the Ministry of Health

The Ministry of Health is the Government’s principal advisor on health and disability in New Zealand. In performing its role, the Ministry carries out activities which include:

- providing policy advice about outcomes and strategies for advancing the health status of New Zealanders, and reducing disparities in health status for Māori and other groups
- developing and maintaining a framework of regulatory health interventions
- establishing and promoting links with other sectors which influence health status and independence
- monitoring Health Funding Authority performance against the objectives agreed with the Government, and monitoring ownership interests in the Health Funding Authority (ie, how effectively and efficiently is the Health Funding Authority managing itself, as opposed to carrying out its funding functions)
- providing informed, independent advice to Ministers about sector performance
- establishing links with health agencies in other countries, for awareness of development of relevance to New Zealand and for benchmarking the performance of New Zealand’s health and disability sector
- providing advice on the protection and improvement of New Zealand’s biosecurity, and the health impact of measures to control biosecurity.

•

Structure

The Ministry presently has the following Branches:

- Policy
- Māori Health
- Performance Management
- Safety & Regulation
- Corporate.

The Ministry's General Management Team comprises the Director-General of Health together with the Deputy Directors-General responsible for particular branches.

Policy Branch provides policy advice on the overall direction and priorities for health and disability. This includes advice on funding levels, the regulatory framework for health and disability services, and inter-sectoral initiatives for improved health and independence.

Safety and Regulation Branch is responsible for the administration of regulation and the enforcement of health and safety legislation (including mental health) and biosecurity. The *Public Health Group* with its statutory responsibilities forms a discrete part of the Safety and Regulation Branch. The establishment of the branch signalled a recognition that the Ministry should maintain a role in the administration of regulation. The aim is to move to a modern regulatory framework based on risk analysis - the Safety and Regulation Branch has as its key task the identification and management of these risks.

Māori Health Branch provides policy advice on the overall strategy for achieving the Government's objective for Māori health: to reduce disparities in health status for Māori by increased responsiveness.

Performance Management Branch manages the Government's purchase and ownership interests in specific Crown entities, including the Health Funding Authority. This involves working in partnership with the health and disability sector to facilitate the achievement of the Government's health and disability goals and objectives. The branch is responsible for developing and implementing annual accountability documents, monitoring and advising on performance and identification and management of issues and risks of non-performance in respect of these Crown entities. This work is complemented by the *National Health Committee Secretariat* which is located in this branch.

Corporate Branch provides corporate and support services to the Minister of Health (and the Associate Ministers) and to the Ministry. The branch includes the Ministry's business units - the New Zealand Health Information Service (NZHIS), the National Radiation Laboratory (NRL), and MedSafe:

- the *National Radiation Laboratory* protects radiation users and the public through implementing the requirements of the radiation protection legislation
- the *New Zealand Health Information Service (NZHIS)* manages national health information systems and statistical collections (see Part 7)

- *MedSafe* is responsible for the approval/licensing of drugs and medical devices in New Zealand.