New Zealand Health and Disability Support Sector
The Organisations
Advice to the incoming Minister of Health

Published in October 2005 by the Ministry of Health
PO Box 5013, Wellington, New Zealand

ISBN 0-478-29675-4 (Book)
HP 4185

This document is available on the Ministry of Health’s website:
http://www.moh.govt.nz
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Introduction

This document describes the major formal organisations of the New Zealand health and disability sector (the sector) and the statutory duties of the Minister of Health (the Minister) in respect of these organisations. It also describes international agreements and contacts that impact on the sector and the Minister’s responsibilities.\(^1\)

Health legislation

The organisation of the sector is dominated by the provisions of the:

- New Zealand Public Health and Disability Act 2000 (the NZPHD Act)
- Health Act 1956

The NZPHD Act outlines the duties of the Minister and the role and functions of District Health Boards (DHBs) and the Ministry of Health (the Ministry). In addition, the NZPHD Act provides for the existence of the National Health Committee, and outlines the roles and functions of the New Zealand Blood Service, Pharmaceutical Management Agency, Residual Health Management Unit (now known as the Crown Health Financing Agency) and a number of ministerial committees.

The Health Act is focused on public health. It sets out the role of the Ministry with regard to public health, and contains provisions for sanitation, pollution, quarantine and infectious diseases, trading in blood and controlled substances, and screening programmes.

The Crown Entities Act provides a consistent framework for the establishment, governance and operation of Crown entities, and clarifies accountability relationships and reporting requirements between Crown entities, their board members, their responsible Ministers on behalf of the Crown, and the House of Representatives.

Health organisations

The major organisations in the sector are the 21 DHBs and the Ministry of Health. These organisations are described in detail in later chapters of this document.

The size and complexity of the sector is reflected in the complexity of the role and the scale of the expenditure administered by the Ministry of Health. In 2005/06 the Ministry will:

- administer close to $10 billion in expenditure
- be responsible for enforcing 102 pieces of specialist legislation, regulations and notices, including 27 Acts.

\(^1\) Information about sector organisations is also available in The Health Sector: The New Zealand directory, published by Health Sector Publications, Masterton, in 2005 and The Health and Disability Sector in New Zealand: A directory, published by the Ministry of Health in 2005. The first of these titles includes extensive information about consumer, provider and health professional groups, while the Ministry’s publication focuses on the formal institutions in the sector.
• administer important payments to primary health care providers and health consumers
• have a strategic role in working with the sector and Ministers to develop and implement policy to improve the health of all New Zealanders.

Agencies outside the sector
A number of organisations and agencies outside the health and disability sector are relevant to the Minister’s role. Of particular importance are the interactions between agencies in the sector (such as the Ministry) and the:

- Accident Compensation Corporation (ACC)
- Specialist Education Services
- Child, Youth and Family Services
- Ministry of Social Development, including:
  - Work and Income
  - Office for Disability Issues
- biosecurity functions of the Ministry of Agriculture and Forestry (MAF) and the Ministry for the Environment.

The sector is more than formal organisations
This document concentrates on the statutory institutional arrangements governing the operation of the sector. However, these arrangements cover only part of the sector. A wide range of advocacy and consumer groups, and health care provider and health professional groups play important roles in the sector. Many non-government and voluntary groups make a significant contribution. Good relationships between the Ministry, district health boards and other statutory organisations and these groups are central to the effective operation of the sector.

Health system facts
In a typical year there will be:
• 15 million visits to general practitioners
• 40 million prescriptions discharged
• 620,000 hospital discharges for medical and surgical treatment
• 88,000 people accessing mental health services
• 414,000 cervical smears taken
• 350,000 free influenza vaccinations
• 61,000 free checks for people with diabetes
• 292,000 assessment, treatment and rehabilitation ‘bed days’ provided for some 14,000 people with disabilities or age-related disorders.
Figure 1: Structure of the New Zealand health and disability sector

Central Government

Minister of Health

Ministerial Advisory Committee

Ministry of Health

• Advise on policy
• Provide health information and process payments
• Facilitate collaboration and co-ordination

Acting on behalf of the Minister to:
• Implement, administer and enforce legislation and regulations
• Plan and fund some services
• Plan and maintain nationwide service frameworks
• Monitor

21 District Health Boards

Private and NGO providers

• Pharmacists, laboratories, radiology clinics
• Primary health organisations, general practitioners, midwives, independent nursing practices
• Voluntary providers
• Community trusts
• Private hospitals
• Māori and Pacific providers
• Disability support services

District Health Board provider arms

Predominantly hospital services, and some community services, public health services, and assessment, treatment and rehabilitation services

New Zealand health and disability support services consumers

New Zealand population and business enterprises
The Minister of Health

The general duty of the Minister of Health is to be responsible to Parliament for the exercise of the functions, duties and powers that are provided for in health legislation.

More specific duties include providing strategic oversight to the sector, exercising powers and responsibilities with respect to DHBs, and making appointments to DHBs, ministerial committees and professional and regulatory boards. These three tasks are described in greater detail in the following paragraphs.

Providing strategic oversight

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

The first editions of the documents presenting these strategies, the New Zealand Health Strategy and the New Zealand Disability Strategy, were published in December 2000 and April 2001, respectively. These documents have already been developed and there is no statutory requirement to review them. If they are reviewed, the NZPHD Act requires consultation with appropriate organisations and individuals.

The NZPHD Act also requires the Minister to oversee the development of a strategy for nationally consistent standards and quality assurance programmes for health services and consumer safety. In September 2003 the Minister of Health released Improving Quality (IQ): A systems approach for the New Zealand health and disability sector, as required under the NZPHD Act, and launched the IQ Action Plan: Supporting the improving quality approach.

The Minister is ultimately responsible for all health policy decisions and all expenditure from Vote Health.

Powers and responsibilities with respect to DHBs

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

The NZPHD Act provides the Minister with a number of powers and responsibilities with respect to DHBs. In particular, the Minister’s consent and approval is required for DHBs’ district strategic plans and district annual plans. The Minister is also responsible for reviewing DHBs’ performance against the objectives agreed with the Government.

The Minister has reserve powers to:

- direct DHBs to give effect to government policy
- appoint Crown monitors to sit on DHB boards
- dismiss DHB boards.
These reserve powers are intended for use in exceptional circumstances only.

At a more general level, the Minister makes the expectations and requirements of the Government clear to DHBs through reiterating the policies in the New Zealand Health Strategy and promulgating planning expectations and funding agreements.

**Appointments**

**DHB boards**

A maximum of 11 members sit on each of the 21 DHBs. Seven members are elected by the community every three years, with the remainder appointed by the Minister of Health. The Minister also appoints the chair and deputy chair of each board. Chairs and deputy chairs can be either elected or appointed members. The chairs, deputy chairs and chief executives of each DHB are listed in Table 4, page 15.

In accordance with the NZPHD Act section 3 (Purpose), section 4 (Treaty of Waitangi) and section 29 (Membership of boards [of District Health Boards]), the Minister is required to ensure that Māori membership of the board is proportional to the number of Māori in the DHB’s resident population, and, in any event, that there are at least two Māori members on the board. This is to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

Each member serves for a maximum of three years initially, although appointed members can be appointed for shorter periods. An elected member can stand for re-election. Appointed members can also be reappointed but are not allowed to serve for more than nine consecutive years.

The NZPHD Act requires DHBs to appoint three advisory committees: a community and public health advisory committee, a disability support advisory committee and a hospital advisory committee. DHBs can also form their own committees (e.g., audit risk and finance committees). The members of these committees are appointed by DHB boards and can be board members or members of the public. Members of the public are usually appointed following consideration of nominations.

**Ministerial committees**

Health legislation requires the Minister to establish a number of committees (compulsory committees), and allows for the establishment of other committees (discretionary committees).

Ministerial committees have an important role in the policy and decision-making process. They provide the Minister with independent expert advice, offer a forum for representatives of the sector to have a role in decision-making, and create pre-conditions for balanced decision-making.

The statutory bases for the major ministerial committees in the health and disability portfolio are outlined in Table 1. Table 1 also shows that ministerial committees can be
divided into advisory committees and deliberative/technical committees. Advisory committees provide the Minister with advice on a particular issue specified in a terms of reference; deliberative/technical committees focus on reviewing individual cases or applications.

The committees in Table 1 are established under the NZPHD Act, the Human Assisted Reproductive Technology (HART) Act 2004, the Medicines Act 1981 and the Health Act 1956. The roles and functions of these ministerial committees are described in greater detail in the ‘Ministerial Committees, Tribunals, Councils and Inspectors’ chapter of this briefing.
<table>
<thead>
<tr>
<th>Type of committee</th>
<th>Name</th>
<th>Discretionary or compulsory</th>
<th>Statutory basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advisory committees</td>
<td>Cancer Control Council</td>
<td>Discretionary; established in 2005</td>
<td>Section 11, NZPHD Act</td>
</tr>
<tr>
<td></td>
<td>Child and Youth Mortality Review Committee</td>
<td>Discretionary</td>
<td>Section 18, NZPHD Act</td>
</tr>
<tr>
<td></td>
<td>Health Workforce Advisory Committee</td>
<td>Discretionary</td>
<td>Section 15, NZPHD Act</td>
</tr>
<tr>
<td></td>
<td>Advisory Committee on Assisted Reproductive Technologies</td>
<td>Compulsory</td>
<td>Section 32, HART Act</td>
</tr>
<tr>
<td></td>
<td>National Ethics Advisory Committee</td>
<td>Compulsory</td>
<td>Section 16, NZPHD Act</td>
</tr>
<tr>
<td></td>
<td>National Health Committee</td>
<td>Discretionary</td>
<td>Section 13, NZPHD Act</td>
</tr>
<tr>
<td></td>
<td>National Health Epidemiology and Quality Assurance Advisory Committee (EpiQual)</td>
<td>Compulsory; established by the National Health Committee</td>
<td>Section 14, NZPHD Act</td>
</tr>
<tr>
<td></td>
<td>Public Health Advisory Committee</td>
<td>Compulsory</td>
<td>Section 17, NZPHD Act</td>
</tr>
<tr>
<td></td>
<td>Health and Disability Ethics Committees</td>
<td>Discretionary</td>
<td>Section 11, NZPHD Act</td>
</tr>
<tr>
<td></td>
<td>Medicines Adverse Reactions Committee</td>
<td>Discretionary</td>
<td>Section 8, Medicines Act</td>
</tr>
<tr>
<td></td>
<td>Medicines Assessment Advisory Committee</td>
<td>Discretionary</td>
<td>Section 8, Medicines Act</td>
</tr>
<tr>
<td></td>
<td>Medicines Classification Committee</td>
<td>Compulsory</td>
<td>Section 9, Medicines Act</td>
</tr>
<tr>
<td></td>
<td>Medicines Review Committee</td>
<td>Compulsory</td>
<td>Section 10, Medicines Act</td>
</tr>
<tr>
<td></td>
<td>Mental Health Review Tribunal</td>
<td>Discretionary</td>
<td>Section 101, MH(CAT) Act*</td>
</tr>
<tr>
<td></td>
<td>Ethics Committee on Assisted Reproductive Technologies</td>
<td>Compulsory</td>
<td>Section 27, HART Act</td>
</tr>
<tr>
<td></td>
<td>National Kaitiaki Group</td>
<td>Discretionary</td>
<td>Section 74, Health Act</td>
</tr>
<tr>
<td></td>
<td>New Prescribers Advisory Committee</td>
<td>Discretionary</td>
<td>Section 8, Medicines Act</td>
</tr>
<tr>
<td></td>
<td>Perinatal and Maternal Mortality Review Committee</td>
<td>Discretionary; to be established</td>
<td>Section 11, NZPHD Act</td>
</tr>
<tr>
<td></td>
<td>Plumbers, Gasfitters and Drainlayers Board</td>
<td>Compulsory</td>
<td>Section 6(2), Plumbers, Gasfitters and Drainlayers Act</td>
</tr>
<tr>
<td></td>
<td>Radiation Protection Advisory Council</td>
<td>Compulsory</td>
<td>Section 5(1), Radiation Protection Act</td>
</tr>
</tbody>
</table>

Notes:
**Professional and regulatory bodies**

The Minister makes appointments to the 15 professional and regulatory bodies established under the Health Practitioners Competence Assurance Act 2003. The Minister is also responsible for a single shared disciplinary tribunal for all boards (the Health Practitioners Disciplinary Tribunal).

The role of the Health Practitioners Disciplinary Tribunal is described more fully in the ‘Ministerial Committees, Tribunals, Councils and Inspectors’ chapter in this briefing.

Each of the 15 professional and regulatory bodies exercises a number of functions with respect to their health profession. These functions include prescribing the qualifications necessary to join their health profession, authorising registration of health practitioners and maintaining registers, ensuring the ongoing competence of health practitioners, and considering cases where health practitioners may be unable to perform the functions required for the practice of the profession.

The 15 professional and regulatory bodies are listed in Table 2, along with the number of ministerial appointments that are made to each body.

**Table 2: Professional and regulatory boards**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Number of ministerial appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Practitioners Disciplinary Tribunal</td>
<td>All 108 panel members, including one chair and three deputy chairs</td>
</tr>
<tr>
<td>Chiropractic Board</td>
<td>All 7 members</td>
</tr>
<tr>
<td>Dental Council of New Zealand</td>
<td>All 14 members</td>
</tr>
<tr>
<td>Dietitians Board</td>
<td>All 7 members</td>
</tr>
<tr>
<td>Medical Council of New Zealand</td>
<td>All 10 members</td>
</tr>
<tr>
<td>Medical Laboratory Science Board</td>
<td>All 8 members</td>
</tr>
<tr>
<td>Medical Radiation Technologists Board</td>
<td>All 10 members</td>
</tr>
<tr>
<td>Midwifery Council</td>
<td>All 8 members</td>
</tr>
<tr>
<td>Nursing Council of New Zealand</td>
<td>All 10 members</td>
</tr>
<tr>
<td>Occupational Therapy Board</td>
<td>All 7 members</td>
</tr>
<tr>
<td>Optometrists and Dispensing Opticians Board</td>
<td>All 10 members</td>
</tr>
<tr>
<td>Osteopathic Council</td>
<td>All 8 members</td>
</tr>
<tr>
<td>Pharmacy Council</td>
<td>All 8 members</td>
</tr>
<tr>
<td>Physiotherapy Board</td>
<td>All 8 members</td>
</tr>
<tr>
<td>Podiatrists Board</td>
<td>All 7 members</td>
</tr>
<tr>
<td>Psychologists Board</td>
<td>All 10 members</td>
</tr>
</tbody>
</table>
District inspectors
The Minister appoints district inspectors under two separate pieces of legislation.

District inspectors of mental health are appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992. These inspectors assist people being assessed or treated under this Act by providing information and support to ensure their rights are upheld.

Some of these district inspectors may have two functions, as they are also appointed under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and perform a similar role with respect to people being cared for or rehabilitated under this Act.

The functions of both types of district inspectors are described more fully later in this document in sections dealing with each these statutes.
District Health Boards

DHBs (http://www.moh.govt.nz/dhb) are the main mechanism for funding and providing publicly funded health and disability services for the population of a specific geographical area. Around three-quarters of Vote Health goes to DHBs, with the Ministry of Health funding many disability support services directly.

There are 21 DHBs, with marked differences in area and population, as shown in Figure 2 and Table 3.

Table 3: DHB populations, 2004¹

<table>
<thead>
<tr>
<th>DHB</th>
<th>Population²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northland</td>
<td>148,000</td>
</tr>
<tr>
<td>Waitemata</td>
<td>488,000</td>
</tr>
<tr>
<td>Auckland</td>
<td>427,000</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>427,000</td>
</tr>
<tr>
<td>Waikato</td>
<td>337,000</td>
</tr>
<tr>
<td>Lakes</td>
<td>102,000</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>197,000</td>
</tr>
<tr>
<td>Tairawhiti</td>
<td>45,000</td>
</tr>
<tr>
<td>Taranaki</td>
<td>107,000</td>
</tr>
<tr>
<td>Hawke’s Bay</td>
<td>150,000</td>
</tr>
<tr>
<td>Whanganui</td>
<td>65,000</td>
</tr>
<tr>
<td>MidCentral</td>
<td>165,000</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>138,000</td>
</tr>
<tr>
<td>Capital and Coast</td>
<td>268,000</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>39,000</td>
</tr>
<tr>
<td>Nelson-Marlborough</td>
<td>133,000</td>
</tr>
<tr>
<td>West Coast</td>
<td>31,000</td>
</tr>
<tr>
<td>Canterbury</td>
<td>461,000</td>
</tr>
<tr>
<td>South Canterbury</td>
<td>54,000</td>
</tr>
<tr>
<td>Otago</td>
<td>180,000</td>
</tr>
<tr>
<td>Southland</td>
<td>108,000</td>
</tr>
</tbody>
</table>

¹ DHB populations are derived from 2004 Statistics New Zealand estimates based on the 2001 Census.
² Totals have been rounded to the nearest 1000. The total estimated population was 4,067,880.

Note: Further DHB population data is available in: R King, C Skelly, B Borman, Atlas of New Zealand’s District Health Boards, Occasional Bulletin Number 13, Public Health Intelligence Unit, Ministry of Health, 2002.

Among others, the objectives of DHBs are to improve and promote the health of people and communities, and promote the integration of health services, especially primary and secondary services.
Since 2000, greater responsibilities have been progressively devolved to DHBs. In October 2003 they took responsibility for providing disability support services to older people (65 years and over). This means that DHBs are now responsible for funding or providing all services except for disability support services for people under 65 years with long-term disabilities, public health, and some national contracts. These areas remain the responsibility of the Ministry.

**Legal status**

DHBs are Crown entities, established under the NZPHD Act and subject to the core public sector accountability statutes, including the Crown Entities Act 2004, the Public Finance Act 1989, the Official Information Act 1982 and the Ombudsmen Act 1975. DHB board members are required to exercise their powers in accordance with any code of conduct that applies to Crown entities, although no code exists at this time. DHBs are legally responsible to the Minister of Health, with the Ministry acting as the Minister’s agent in managing the formal relationship through the chair of the board of each DHB.

**Objectives and responsibilities**

DHBs are required to undertake their functions according to a set of population health objectives set out in sections 22 and 23 of the NZPHD Act. These objectives centre on protecting and improving the health of their communities, and fostering the independence of people with disabilities. These objectives are to be achieved by promoting the integration of health services, ensuring the provision of effective health and disability support services, and reducing disparities.

DHBs are also required to promote social responsibility, community participation in decision-making, transparent decision-making, and prudent management of Crown-owned assets, and to act in a co-operative manner. In particular, they are expected to co-operate with adjoining boards to deliver services, such as specialist services that draw patients from a larger area than is covered by a single DHB.

**DHBs and Māori**

The role of DHBs has been set by Parliament in the NZPHD Act. The Act refers to mechanisms to enable Māori to contribute to decision-making on, and to participate in, the delivery of health and disability support services.

The NZPHD Act also has the objective of reducing health disparities by improving health outcomes for Māori. There are a number of mechanisms for achieving this objective, such as requirements for Māori representation on DHB boards and advisory committees. Also, DHB board members not familiar with, among other topics, Māori health issues, Treaty of Waitangi issues, and the Māori groups and organisations in the district of the DHB concerned are required by a schedule to the NZPHD Act to be trained in these areas.
Further opportunities for participation by Māori are provided for by requirements to:

- establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement
- continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori
- provide relevant information to Māori for the above two requirements.

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

He Korowai Oranga: Māori Health Strategy (2002) takes this principle to the next stage and provides more detail on how it is to be implemented. The strategy is underpinned by three principles of the Treaty of Waitangi – partnership, participation and protection – and is given effect by Whakatätaka: Māori Health Action Plan 2002–2005. The New Zealand Disability Strategy also reiterates these three principles, and DHBs are expected to show how they intend to put these principles into effect.

**DHBs and PHOs**

Primary Health Organisations (PHOs) are funded by DHBs to provide a set of essential primary health care services to those people who are enrolled with the PHO. Each PHO has a contract with its DHB to provide these services, called the Primary Health Organisation Agreement, which is currently at version 17. The DHB is responsible for monitoring whether its PHO(s) is/are delivering services according to the agreement. PHOs can take a variety of legal forms, such as a non-profit company, an incorporated society or a trust.

PHOs are described in more detail in the ‘Provider and Consumer Community’ chapter of this briefing.

**Accountability mechanisms**

The Crown Entities Act 2004 requires DHBs to prepare:

- a statement of intent, for tabling in Parliament (specified in sections 138–149)
- an annual report to Parliament (specified in sections 150–157 of the Act).

The NZPHD Act requires DHBs to have a set of formal accountability documents, including annual financial statements and planning documents. These are:

- the Crown Funding Agreement, specified in section 10 of the Act
- a district strategic plan, specified in section 38 of the Act
- a district annual plan, specified in section 39 of the Act.
The Crown Funding Agreement is the formal accountability agreement between the Minister and each DHB. It includes performance expectations for DHBs in exchange for the Minister’s formal agreement to defined levels of funding.

The Crown Funding Agreement also formally obliges DHBs to comply with an Operating Policy Framework and Service Coverage Schedule. The Operating Policy Framework provides detail on how the Ministry expects key aspects of DHBs’ functions, such as finance monitoring and relations with Māori, to be carried out in practice. The Service Coverage Schedule describes the nationwide minimum service coverage of health and disability support services the Government expects will be made available through Vote Health.

District strategic plans spell out DHBs’ medium- to long-term goals for the health of their populations, while district annual plans spell out DHBs’ short-term objectives, including the range of services they will provide for their populations.

In addition to formal accountability documents, the Ministry maintains close contact with DHBs through account manager relationships, quarterly DHB chairs’ conferences and regular meetings between DHB chief executives and the Ministry’s Deputy Directors-General.

**DHB-owned organisations**

DHBs own a range of organisations, including DHB-controlled companies, companies controlled in conjunction with other Crown entities, companies in which DHBs have a minority interest, trusts and incorporated societies, and unincorporated joint ventures and partnerships.

DHB-owned public health units and shared support services are discussed below.

**Public health units**

Public health services are delivered by 12 DHB-owned public health units and various non-governmental organisations (NGOs). DHB-based services and NGOs each deliver approximately half of such services. Public health services are funded by the Ministry of Health.

Public health units focus on ‘core public health services’, as specified in the *Public Health Services Handbook*, including environmental health, communicable disease control, tobacco control and health promotion programmes. Many of these services include a regulatory component performed by statutory officers appointed under a variety of legislation, though principally under the Health Act 1956. These statutory officers are employed by DHBs but are personally accountable to, and subject to, direction from the Director-General of Health. Statutory officers also work closely with the Ministry’s Public Health Directorate in respect of funding, co-ordination of services and ongoing support.
Shared services agencies

In some areas DHBs have pooled their resources to obtain common support services through jointly owned companies. Examples of shared services agencies include the Northern Clinical Training Network Ltd, HealthIntelligence Ltd, and the South Island Shared Services Agency Ltd.

District Health Boards New Zealand

DHBs have formed a national umbrella organisation called District Health Boards New Zealand Incorporated, known as DHBNZ (http://www.dhbnz.org.nz). DHBNZ is an incorporated society and its role is to co-ordinate joint DHB initiatives and to communicate with the Government and the Ministry over matters that affect all DHBs. There is no statutory relationship between the Crown and DHBNZ.

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

- develop national frameworks for pricing, contracting, service development and specifications
- facilitate the sharing of project resources
- identify and promote best practice
- provide applied analysis to inform strategies for workforce planning and development, and employee relations and agreements
- co-ordinate DHB operational activity related to planning and funding national services.
Table 4:  DHB chairs, deputy chairs and chief executives, as at 19 July 2004

<table>
<thead>
<tr>
<th>DHB</th>
<th>Chair (elected or appointed)</th>
<th>Deputy chair (elected or appointed)</th>
<th>Chief executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northland</td>
<td>Lynette Stewart (appointed)</td>
<td>Stan Semenoff (elected)</td>
<td>Karyn McPeake</td>
</tr>
<tr>
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<td>Michael Ludbrook (appointed)</td>
<td>Sally Christie (elected)</td>
<td>Brent Wiseman (acting)</td>
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<td>Joan Williamson-Orr (elected)</td>
<td>Cathy Cooney</td>
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<td>Graeme Horsley (appointed)</td>
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<td>David Marshall (elected)</td>
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<td>Patrick O’Connor (appointed)</td>
<td>Ormond Stock (appointed)</td>
<td>Memo Musa</td>
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<td>Ian Wilson (appointed)</td>
<td>Ann Chapman (elected)</td>
<td>Murray Georgel</td>
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<td>Hutt Valley</td>
<td>Peter Glensor (elected)</td>
<td>Sharron Cole (appointed)</td>
<td>Chai Chuah</td>
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<td>Capital and Coast</td>
<td>Bob Henare (appointed)</td>
<td>Judith Aitken (elected)</td>
<td>Margot Mains</td>
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<td>Doug Matheson (appointed)</td>
<td>Janine Vollebregt (elected)</td>
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<td>Nelson-Marlborough</td>
<td>Liz Richards (acting, elected)</td>
<td>Liz Richards (elected)</td>
<td>John Peters</td>
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<td>Gregor Coster (appointed)</td>
<td>Christine Robertson (appointed)</td>
<td>Kevin Hague</td>
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<tr>
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<td>Syd Bradley (appointed)</td>
<td>Olive Webb (elected)</td>
<td>Karleen Edwards (acting) Gordon Davies (from mid-November)</td>
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<tr>
<td>South Canterbury</td>
<td>Joe Butterfield (appointed)</td>
<td>Neil Anderson (elected)</td>
<td>Craig Climo</td>
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<td>Otago</td>
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<td>Louise Rosson (elected)</td>
<td>Brian Rousseau</td>
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<td>Southland</td>
<td>Dennis Cairns (appointed)</td>
<td>Neville Cook (elected)</td>
<td>Gershu Paul</td>
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The Ministry of Health

The Ministry of Health’s goal is ‘Healthy New Zealanders’. The Ministry aims for better health, reduced inequalities, better participation and independence, and trust and security in the health and disability support system.

The Ministry’s outcomes framework (Figure 3) sets out how the Ministry works to achieve the goal of ‘Healthy New Zealanders’.

Roles of the Ministry

The Ministry has eight key responsibilities. These are to:

- provide policy advice on improving health outcomes, reducing inequalities and increasing participation
- act as the Minister’s agent
- monitor the performance of DHBs and health sector Crown entities
- implement, administer and enforce relevant legislation and regulations
- provide health information and process payments
- facilitate collaboration and co-ordination within and across sectors
- provide nationwide planning and maintenance of service agreements
- plan and fund public health, disability support services and other services that are retained centrally.

These roles are explained further in the following paragraphs.

Providing policy advice

The Ministry is the Ministers’ and the Government’s primary advisor on health and disability support services policy.

Acting as the Minister’s agent

The Ministry acts as the agent of the Minister of Health (and Associate Ministers of Health) in a number of ways. For example, the Ministry acts as an agent in managing the formal relationship with DHBs and is an intermediary between the Minister and representatives of the sector.

The Ministry also provides the Minister (and Associate Ministers) with a range of ministerial support services. These services enable the Minister to respond to the large volume of correspondence, parliamentary questions and other enquiries received.
Monitoring the performance of DHBs

The Ministry monitors the performance of DHBs and other Crown entities in the sector against the objectives agreed with the Government. The Ministry also monitors the performance of the sector in an international context, with a focus on international benchmarks.

Figure 3: Ministry of Health Statement of Intent outcomes framework
Facts about the Ministry of Health

- In September 2005, 543 full-time equivalent staff were employed across the Ministry’s six regional offices and eight directorates.
- A further 414 staff were employed in the Ministry’s business units.
- The total Vote Health budget for 2005/06 is $9.68 billion, including $150 million for the Ministry (all GST exclusive).
- The Ministry aims to be knowledge-based, people-centred and systems-minded.

Implementing, administering and enforcing legislation and regulations

The Ministry administers and enforces 27 Acts and about 75 regulations, primarily to protect patient safety and public health. The Ministry also works with other agencies to safeguard public safety with respect to environmental and public health issues such as biosecurity.

Providing health information and processing payments

The Ministry has governance over health information systems and standards across the sector. It is also responsible for ensuring health and disability information is accessible for providers and consumers wherever appropriate and practical.

The Ministry’s responsibility for processing payments is summarised in the paragraphs about HealthPAC under ‘Structure of the Ministry: Directorates and business units’ (below).

Facilitating collaboration and co-ordination

The Ministry is involved in establishing and promoting links within the sector, providing strategic direction and leadership to the sector, and promoting links with other sectors that influence health status and independence.

Nationwide planning and maintenance of service frameworks

The Ministry plans and maintains nationwide frameworks and specifications for services. This includes an overview of nationwide planning for capital development.

Planning and funding selected services

The Ministry is responsible for planning and funding public health services and disability support services for people under the age of 65, and nationwide funding agreements for selected personal and family health services.

Structure of the Ministry: Directorates and business units

The Ministry consists of eight functionally based directorates, the office of the Director-General of Health and the office of the Chief Internal Auditor. A Deputy Director-General heads each directorate. The Deputy Directors-General, the Director-General and the Principal Medical Advisor collectively form the Executive Team.
Almost half of the Ministry’s staff are employed in the service arms and business units of the Ministry, including the Clinical Training Agency, HealthPAC, Information Technology Shared Services, New Zealand Health Information Service, Medsafe, National Screening Unit and National Radiation Laboratory. These operational arms sit within the relevant directorates and are a vital part of the supporting infrastructure for the sector.

This section explains the roles and functions of the eight directorates and their business units.

**Corporate and Information**

The Corporate and Information Directorate (CID) provides health payment and agreement management through HealthPAC, a range of information and technology services (including specialist information through the New Zealand Health Information Service), corporate and sector financial services, and other support services within the Ministry, including media and communication services, human resource management and legal advice. CID also provides ministerial support services to the Minister and Associate Minister(s) of Health. This facility helps manage the high volume of correspondence received by Ministers’ offices and the large number of parliamentary questions and requests for official information received by the Minister of Health. CID also provides advice on health sector information and technology issues.

Debbie Chin is Deputy Director-General, CID.

CID includes three business units: HealthPAC, Information Technology Shared Services and the New Zealand Health Information Service (NZHIS).

**HealthPAC**

Health Payments, Agreements and Compliance (HealthPAC) reports to the Deputy Director-General, Corporate and Information Directorate.

HealthPAC has four main functions:
- to create and manage agreements (service contracts for health and disability services)
- to process and pay claims for medical services and pharmaceuticals (although claims for some of these services are now being paid via DHBs)
- to provide information to the Ministry, DHBs and providers
- to carry out appropriate audit and compliance functions.

HealthPAC administers claims from providers, including pharmacists and general practitioners, and for immunisation, dentistry and maternity services. HealthPAC also processes pharmaceutical claims from hospitals and drug wholesalers and is responsible for paying claims from consumers for diagnostic imaging, prostheses and hairpiece payments. All of the different types of claims cost approximately $7 billion in 2004/05.
The scale of payments means that HealthPAC’s audit functions are especially important. Investigations are conducted where there is evidence of systematic inappropriate claiming or fraud. Serious cases are submitted to the appropriate professional disciplinary body, the Office of the Health and Disability Commissioner, or a court of law.

HealthPAC has four offices around the country. The Wanganui Centre is responsible for processing all pharmaceutical claims and the Wellington Centre for processing claims for medical and medically related services. The audit and compliance functions are based in Christchurch and Wanganui. The Dunedin office provides a helpdesk facility and the infrastructure to manage agreements with providers.

Jeannie Bathgate is Group Manager of HealthPAC (until February 2006).

Information Technology Shared Services
Information Technology Shared Services provides information technology services to DHBs, via HealthPAC and NZHIS, and to the Ministry.

Warwick Sullivan is Chief Technology Officer.

New Zealand Health Information Service
The New Zealand Health Information Service (NZHIS) is a specialist business unit of the Ministry’s Corporate and Information Directorate responsible for the collection, processing and dissemination of health data, health statistics and health information. The NZHIS maintains and develops national health and disability information systems and quality-audit programmes for data. The NZHIS also provides database management, data analysis, benchmarking and advice on the use of health information.

The NZHIS maintains several major information systems: the National Health Index, Medical Warning System, National Minimum Dataset, Private Hospital Reporting System, Cause-of-Death Database and New Zealand Cancer Registry. The New Zealand Cancer Registry meets the requirement in the Cancer Registry Act 1993 for the Director-General of Health to maintain or arrange for the maintenance of a cancer registry. The NZHIS manages the Registry on behalf of the Director-General of Health.

The NZHIS also administers the Workforce Collection, Mental Health Information National Collection, National Booking Reporting System, Maternity and Newborn Information Collection, Pharmhouse Warehouse, Laboratory Warehouse, Immunisation Data Warehouse, Hepatitis B Data Warehouse and BreastScreen Aotearoa programme. These information systems are used to inform decisions on policy, funding and health care delivery.

Mike Rillstone is Group Manager of the NZHIS (until October 2005).
Clinical Services

The Clinical Services Directorate has the responsibility for developing primary health care, and for overseeing the strategic development of hospital services and approaches linking primary and secondary services, including implementation of the Primary Health Care Strategy. It provides advice on specialist health services such as oral health, child and youth health, quality improvement, acute care and emergency services, cancer and radiotherapy, and aspects of Pacific peoples’ health. HealthCert, which is responsible for the administration of safety and facility licensing legislation, is part of the Clinical Services Directorate, and the directorate also oversees quality improvement initiatives across the sector. The Clinical Services Directorate is also responsible for managing key relationships with clinical representatives, especially via the directorate’s Chief Advisor position.

Dr Colin Feek is Deputy Director-General, Clinical Services Directorate.

DHB Funding and Performance

The DHB Funding and Performance Directorate has a dual role: it is responsible for managing the Crown’s funding and ownership interests in DHBs and Crown entities, and for funding agreements for services, including national maternity services.

Gordon Davies is Deputy Director-General, DHB Funding and Performance Directorate until October.

The DHB Funding and Performance Directorate includes one business unit, the Clinical Training Agency.

Clinical Training Agency

The Clinical Training Agency’s role is to purchase post-entry clinical training. This means training that is substantially clinical, vocational, nationally recognised and a minimum of six months long, and occurs after entry into a health profession.

The Clinical Training Agency is also involved in workforce analysis and development. This includes joint projects with the Mental Health, Disability Services, Māori Health and Sector Policy Directorates, as well as utilising sector reference groups. The Clinical Training Agency also has responsibility for the Overseas Trained Doctors Programme and for funds managed on behalf of the Mental Health Directorate.

Disability Services

The Disability Services Directorate is responsible for the development of disability support services policy, service development, planning and funding of disability support services, the strategic direction of the disability support services sector, and future options for meeting the disability support services needs of younger people.
The directorate contributes to the implementation of the New Zealand Disability Strategy, working in association with the Office for Disability Issues.

Geraldine Woods is Deputy Director-General, Disability Services Directorate.

Māori Health
The Māori Health Directorate provides policy advice on the strategies and frameworks for achieving the Government’s objective of improving the health status of Māori and reducing disparities in health between Māori and other New Zealanders, appropriate service development, building relationships with Māori, and Māori service provision.

Ria Earp is Deputy Director-General, Māori Health.

Mental Health
The Mental Health Directorate is responsible for implementing the Mental Health Strategy, for advice on and management of issues in mental health, for the administration of mental health legislation, and for drug and alcohol treatment regulation.

Dr Janice Wilson is Deputy Director-General, Mental Health Directorate.

Public Health
The Public Health Directorate is responsible for the development of public health policy, the planning and funding of public health services, and public health legislation. The Directorate also administers payments for publicly funded public health services.

Dr Don Matheson is Deputy Director-General, Public Health Directorate.

The Public Health Directorate includes four business units: Medsafe, the National Radiation Laboratory, the National Screening Unit, and Public Health Intelligence.

Medsafe
The New Zealand Medicines and Medical Devices Safety Authority (Medsafe) is responsible for the regulation of therapeutic products in New Zealand to maximise safety and benefit. Therapeutic products include medicines and related products, herbal remedies, and controlled drugs used as medicines. Medsafe enforces product safety through pre-marketing approval for new and changed medicines. It also monitors the safety of medicines and medical devices in use.

Medsafe also has formal responsibility for administering the Medicines Act 1981 and Medicines Regulations 1984, and parts of the Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977.
The New Zealand and Australian governments have agreed to establish a trans-Tasman therapeutic goods agency to replace the Therapeutic Goods Administration in Australia and Medsafe in New Zealand. The joint agency will regulate medicines, medical devices, complementary medicines and dietary supplements. A project team of Australian and New Zealand officials from a variety of agencies including, in New Zealand, the Ministry of Heath, Treasury, State Services Commission and Ministry of Foreign Affairs and Trade, has been established to develop the detail of how the agency would operate and progress new legislation to regulate therapeutic goods in both countries.

**National Radiation Laboratory**

The National Radiation Laboratory is based in Christchurch. It provides expert advice, service provision and research capability relating to public, occupational and medical exposure to radiation, the performance of radiation equipment and the measurement of radiation and radioactivity.

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

The Radiation Protection Act restricts the use of radioactive materials or irradiating apparatus to people holding a licence. Applications for some classes of licence for medical purposes must be referred to the Medical Licensing Advisory Committee. The Act also sets up an advisory body called the Radiation Protection Advisory Council to advise the Minister and the Director-General about licensing decisions and matters of policy.

Jim Turnbull is Group Manager of the National Radiation Laboratory.

**National Screening Unit**

The National Screening Unit was established in 2001 to provide an umbrella for screening services. The Unit is responsible for the national co-ordination of the BreastScreen Aotearoa programme (established 1998) and the National Cervical Screening Programme (established 1990). The National Screening Unit is also now responsible for antenatal HIV screening, and newborn and metabolic screening, and is examining policy relating to screening of newborn hearing, antenatal Downs, colorectal cancer and chlamydia.

BreastScreen Aotearoa aims to screen 70 percent of women in the eligible 45 to 69 years age group. The extension of the age range in July 2004 made breast screening available to a further 216,000 women, in addition to more than 328,000 women aged 50–64 already covered by the programme.
Since July 2004, 6600 women aged 45 to 49 and 27,500 women aged 65 to 69 have been screened. As at May 2005 approximately 20,000 women aged 45 to 49 had enrolled in the programme. These women have been sent, or are being sent, a letter stating that they will be screened within 12 to 18 months.

The National Cervical Screening Programme involves health promotion, smear-taking, laboratory analysis of cervical smears and cervical biopsies, and management of women with abnormal cervical smear results. The Programme’s recruitment focus is on women aged 20 to 69 years who have never had a smear or whose previous smear was more than five years ago, women aged over 50 years, and Māori and Pacific women.

Karen Mitchell is Group Manager of the National Screening Unit.

Public Health Intelligence
Public Health Intelligence carries out the Ministry of Health’s statutory responsibility to monitor the health of the population over time by analysing population health outcomes, risks and determinants, and by examining inequalities in health across regional boundaries and between population groups (including age, gender, ethnic and socioeconomic groups). Public Health Intelligence provides analytical services and training to the Ministry of Health and the wider sector, as well as working collaboratively with a variety of national and international academic and health agencies.

Barry Borman is Manager of Public Health Intelligence.

Sector Policy
The Sector Policy Directorate provides strategic policy advice to the Government across all aspects of the health and disability sectors, with a particular focus on long-term funding requirements, the health workforce, regulatory frameworks, health system monitoring, the New Zealand Health Strategy, the health of older people, international issues, and assessing the implications of emerging issues for the health sector. The Sector Policy Directorate is leading policy and legislation development, and is responsible for negotiations with Australia to establish the Joint Therapeutic Products Agency.

The Directorate administers the health professional statutes. It also provides secretarial and administrative support for a number of ministerial committees, including the Health Workforce Advisory Committee, National Ethics Advisory Committee, National Ethics Committee on Assisted Human Reproduction, National Health Committee, and the seven Regional Health and Disability Ethics Committees.

Mark Booth is Acting Deputy Director-General, Sector Policy Directorate, and a new appointment is pending.
Positions and people

Statutory positions within the Ministry of Health

Director-General of Health

The Director-General of Health is the chief executive of the Ministry and, like all other public service chief executives, is appointed on a time-limited contract by the State Services Commissioner under the State Sector Act 1988. This Act specifies that chief executives are responsible to their Ministers for:

- carrying out the functions and duties of their organisation
- tendering advice to Ministers of the Crown
- the general conduct of their organisation
- the efficient, effective and economical management of the activities of their organisation.

In addition, the Director-General has a number of statutory powers and responsibilities under various pieces of health legislation. These include:

- powers relating to quarantine and public health emergencies under the Health Act 1956
- certifying providers under the Health and Disability Services (Safety) Act 2001
- issuing guidelines under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and other acts.

Dr Karen Poutasi is the Director-General of Health.

Director and Deputy Director of Mental Health

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

Dr David Chaplow is the Director of Mental Health. Dr Jeremy Skipworth is the Deputy Director of Mental Health.

Director of Public Health

The statutory position of Director of Public Health is located in the Public Health Directorate. This position is provided for in the Health Act 1956 as an independent advisory role. It gives the Director the authority to directly advise the Director-General and Minister on public health and regulatory matters relating to public health.

Dr Mark Jacobs is the Director of Public Health.
Chief Financial Officer
The Public Finance Act 1989 requires all departments to have a chief financial officer responsible for signing departments’ statements of intent and annual accounts.

Paul Helm is the Chief Financial Officer.

Principal Medical Advisor
A part-time seconded role, the Principal Medical Advisor is responsible for informing the Minister and Ministry of the views of the sector.

Dr David Galler is the Principal Medical Advisor.

The Executive Team
The Executive Team (Link) comprises the Director-General of Health (Dr Karen Poutasi), the Principal Medical Advisor (Dr David Galler), and the eight Deputy Directors-General, each of whom heads one of the Ministry’s eight directorates:

- Debbie Chin Corporate and Information Directorate
- Mark Booth (acting) Sector Policy Directorate
- Gordon Davies DHB Funding and Performance Directorate
- Ria Earp Māori Health Directorate
- Dr Colin Feek Clinical Services Directorate
- Dr Don Matheson Public Health Directorate
- Dr Janice Wilson Mental Health Directorate
- Geraldine Woods Disability Services Directorate.

Chief advisors
The Ministry’s chief advisors (link) represent the Ministry of Health in the health and disability sector. They bring to their roles a vast range of expertise and experience in health management and service delivery, and continue to consult with others working in the sector.

The first chief advisor position was set up in 1993, and the Ministry has created a number of chief advisor positions as part of an ongoing strategy to improve the development of health policy advice. The roles of the chief advisors will help to ensure that the views and advice from health professionals and others in the sector are reflected in the Ministry’s work and policy development.

The chief advisors are:

- Grant Adam Chief Legal Advisor
- Dr Ashley Bloomfield Chief Advisor, Public Health
- Steve Brazier Chief Internal Auditor
- Dr David Chaplow Chief Advisor, Mental Health
• Dr David Geddis Chief Medical Advisor
• Gillian Grew Chief Advisor, Services
• Mark Jones Chief Advisor, Nursing
• Wi Keelan Chief Advisor, Māori Health
• Brendan Kelly Chief Advisor, Health Information Strategy and Policy, NZHIS
• Lester Mundell Chief Advisor, Disability Support Services
• Dr Jim Primrose Chief Advisor, General Practice
• Frances Ross Chief Advisor, Media
• Dr Debbie Ryan Chief Advisor, Pacific Health
• Dr Pat Tuohy Chief Advisor, Child and Youth Health
• Robin Whyman Chief Advisor, Oral Health
• Dr John Childs Principal Advisor, Cancer Control.

2 The position of Chief Medical Advisor (which is filled by Dr David Geddis) is different from that of Principal Medical Advisor (Dr David Galler). The former is a full-time role, advising the Ministry and Minister on a range of medical issues, while the latter role is part-time and focuses on informing the Minister and Ministry of views from the sector.
Other Organisations in the Health Sector

This chapter describes a number of other statutory organisations and Crown entities in the health and disability sector.

Organisations provided for in the Crown Entities Act 2004 and NZPHD Act 2000

In addition to the Ministry and DHBs, the Crown Entities Act 2004 and NZPHD Act 2000 provide for the existence of the New Zealand Blood Service, PHARMAC and the Crown Health Financing Agency, among others.

These organisations are described in more detail in the following paragraphs.

New Zealand Blood Service

The New Zealand Blood Service (NZBS) was established as a company in 1998, and is now a Crown entity (statutory entity) under the Crown Entities Act 2004. The Act provides the Minister with the power to direct the NZBS to give effect to government policy as it relates to the entity’s functions and objectives.

The NZBS initially had responsibility for establishing an integrated national blood transfusion service, which is now in place. It continues to be responsible for managing the donation, collection, processing and supply of blood products and related services. The NZBS's core activity is the safe, timely, high-quality and efficient provision of blood services.

The NZBS is governed by a board that can have up to seven members, including the chair, all of whom are appointed by the Minister. There are currently five members on the board. The chair is Mr Warren Young.

PHARMAC

PHARMAC, the Pharmaceutical Management Agency, was established in 1993 and is now a Crown entity (statutory entity) under the Crown Entities Act. PHARMAC is directly accountable to the Minister of Health. PHARMAC’s overall objective is to secure the best health outcomes that are reasonably achievable from pharmaceutical treatment within the funding provided. Section 103 of the Crown Entities Act 2004 provides the Minister with the power to give PHARMAC directions to give effect to government policy.

PHARMAC manages the Pharmaceutical Schedule (the Schedule), which lists around 3000 prescription medicines and related products subsidised by the Government. Since September 2001 PHARMAC has also been responsible for managing the purchasing of all pharmaceuticals used by, or on behalf of, DHBs, including some hospital drugs.

Pharmaceutical suppliers may apply to PHARMAC to have a medicine listed on the Schedule once the product has been registered. The PHARMAC Board makes decisions on listing, subsidy levels, and prescribing guidelines and conditions with input
from independent medical experts on the Pharmacology and Therapeutics Advisory Committee.

The PHARMAC Board can have up to six members, including the chair, all of whom are appointed by the Minister of Health. There is currently a full complement of members. The chair is Richard Waddell.

Crown Health Financing Agency (previously Residual Health Management Unit)

The Residual Health Management Unit (RHMU) was established in 1993 to assume responsibility for area health board assets and liabilities that were not otherwise vested with Crown health enterprises, regional health authorities or the Ministry of Health. RHMU was subsequently continued under section 57 of the NZPHD Act.

The replacement agency for RHMU, the Crown Health Financing Agency (CHFA), operates as a statutory Crown entity under the Crown Entities Act 2004. Section 65 of the NZPHD Act provides the Minister with the power to give the CHFA directions relating to government policy.

CHFA has three main functions:
- lending funds to DHBs
- advising DHBs that wish to sell surplus property
- managing residual assets and liabilities.

In 2000, the government decided that DHBs should not borrow from the private sector except for working capital for facilities. The CHFA was appointed as the Crown’s lender to the DHB sector in June 2001. Well established as a fully operational lending organisation, the CHFA provides DHBs with a range of term loan facilities broadly similar to a commercial lending organisation, and has established loan application, credit assessment and monitoring procedures. The CHFA has to approve a DHB’s business case before funds are provided, and it also sets the terms and conditions of the loans and ensures repayment and compliance with the loan conditions.

The CHFA is also responsible for assisting the DHB sector to dispose of surplus property by either buying surplus DHB property assets for the purpose of selling them on the open market, or by holding properties by way of transfer or other means and managing them until disposal. The CHFA also provides strategic advice to the health sector in respect of property disposal and other related transactions.

The CHFA has taken over the debt of the former area health boards that had not been incorporated in the balance sheets of the new Crown health enterprises or other Crown transferees. Some $700 million was involved, with repayments extending out until the year 2006. The debt has progressively been repaid. As at 30 June 2005, $20.1 million remained outstanding. The CHFA has confirmed (31 August 2005) that this debt is in the form of bonds that will be repaid in June 2006.

Key stakeholders for the CHFA are the Minister of Health as the responsible Minister for the CHFA, the Minister of Finance as joint responsible Minister for the CHFA, and their officials.
There are currently four members including the chair, Ross Tanner.

**Accident Compensation Corporation**

The accident compensation scheme is a 24-hour-a-day, seven-day-a-week no-fault scheme that provides treatment, rehabilitation and compensation for New Zealand citizens and residents, and temporary visitors to New Zealand, who suffer personal injury through accident in New Zealand. In return, people who are covered under accident compensation legislation may not sue for personal injury, other than for exemplary damages.

From 1 July 2005 medical misadventure was replaced by a new category called ‘treatment injury’. The new criteria for treatment injury will remove the requirement on the Accident Compensation Corporation (ACC) to find fault (medical error) with the actions of a registered health professional or organisation or to prove that a medical injury is rare or severe before a patient is entitled to ACC cover.

ACC is the Crown entity responsible for administering the accident compensation scheme. Its responsibilities are:

- preventing injuries
- collecting accident levies
- determining whether claims for injury are covered by the scheme and providing entitlements to people who are eligible
- paying compensation
- buying health and disability support services to treat, care for and rehabilitate injured people
- advising the Government.

ACC is funded principally by levies collected from a range of sources, including employers, self-employed people, employees, and motor vehicle licensing. ACC also receives direct government funding, although it is not funded from Vote Health.

**Alcohol Advisory Council of New Zealand**

The Alcohol Advisory Council of New Zealand (ALAC) was established under the Alcoholic Liquor Advisory Council Act 1976 and is an autonomous Crown entity for the purposes of the Crown Entities Act 2004. ALAC’s primary objective is to encourage and promote moderation in the use of alcohol, and to develop and promote strategies that will reduce alcohol-related harm in New Zealand. ALAC is funded by a levy on all alcohol imported into, or manufactured in, New Zealand. This levy raises approximately $11 million per annum.

ALAC is governed by the ALAC Council, which is appointed by the Minister of Health under section 28(1)(a) of the Crown Entities Act 2004. The Council meets monthly to
consider policy issues, to receive reports or working papers from ALAC staff, and to consider funding applications.

The ALAC Council has up to eight members including the chair, all of whom are appointed by the Minister. There is currently a full complement of members. The chair is Professor Andrew Hornblow.

Health Research Council of New Zealand

The Health Research Council of New Zealand is a statutory entity under the Crown Entities Act 2004 and is governed by the Health Research Council Act 1990. It is the major government agency for funding and co-ordinating health research and fostering the health research workforce. It is funded through the Ministry of Research, Science and Technology.

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

The Health Research Council has up to 10 members including the chair, all of whom are appointed by the Minister. There is currently one vacancy. The chair is Professor Graeme Fraser, and the chief executive is Dr Bruce Scoggins.

Health Sponsorship Council

The Health Sponsorship Council was established by the Smokefree Environments Act 1990 and it is a statutory entity under the Crown Entities Act 2004. Its principal function is to promote health and encourage healthy attitudes and lifestyles. The Council provides sponsorship for sporting, artistic, cultural and recreational organisations in return for the promotion of these messages.

The Health Sponsorship Council has developed four health brands: Smokefree, Auahi Kore, SunSmart and Bike Wise. It is also a key contributor to the ‘Quit’ and ‘Me Mutu’ messages and had a central role in the development of the national Quitline service.

The Council board has up to six members including the chair, all of whom are appointed by the Minister of Health. There is currently a full complement of members. The chair is Athol Mann.

Mental Health Commission

The Commission is responsible for reporting to the Minister of Health on the implementation of the National Mental Health Strategy. It is also responsible for facilitating the implementation of the Blueprint for Mental Health Services in New Zealand. The Blueprint is a national mental health service development plan setting out the qualitative and quantitative changes needed to realise the objectives of the National Mental Health Strategy. The Commission also works with the sector to promote better public understanding of mental illness, eliminate discrimination and strengthen the mental health workforce.

There is a maximum of three mental health commissioners at any time, including the chair, all of whom are appointed by the Minister of Health. There is currently a full complement of commissioners. The chair of the Commission is Ruth Harrison; the other commissioners are Bob Henare and Mary O’Hagan.

**Office for Disability Issues**

The Office for Disability Issues is located within the Ministry for Social Development. It reports directly to the Minister for Disability Issues and provides advice to that Minister on disability issues across all sectors. The Office also leads the implementation and monitoring of the New Zealand Disability Strategy across the public sector.
Ministerial Committees, Tribunals, Councils and Inspectors

This chapter contains brief descriptions of the roles, functions and statutory bases of the bodies to which the Minister appoints members, excluding DHB boards and the 15 professional and regulatory bodies, whose functions are described earlier in this document.

The chapter is divided alphabetically by statute of establishment.

Under the Health Act 1956

National Kaitiaki Group

Under the Health (Cervical Screening (Kaitiaki)) Regulations, the National Kaitiaki Group is a ministerially established group with responsibility for granting or declining applications to use, publish or disclose Māori women’s aggregate data held on the National Cervical Screening Register. In determining whether or not to grant an approval, the National Kaitiaki Group must have regard to the following matters:

- the principle of te whare tangata or sanctity of the womb
- the need for culturally appropriate protection of the taonga (Māori women’s aggregate data held on the National Cervical Screening Register)
- the need to ensure that protected information is used for the benefit of Māori women.

The National Kaitiaki Group meets no more than four times per year. There are currently five members, and Kiri Rikihana is the convenor.

Under the Health Practitioners Competence Assurance Act 2003

Health Practitioners Disciplinary Tribunal

The Health Practitioners Disciplinary Tribunal was established in September 2004 under the Health Practitioners Competence Assurance Act 2003. The Tribunal hears and determines disciplinary proceedings against health practitioners. It comprises a chair, three deputy chairs, and a panel of laypersons and health practitioners. The total membership of the Tribunal is 108, all of whom are appointed by the Minister. However, only five members of the Tribunal (the chair or a deputy, one layperson and three professional peers of the health practitioner who is the subject of the hearing) sit on each case.

The chair of the Health Practitioners Disciplinary Tribunal is Dr David Collins QC.
Under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

District inspectors
The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 establishes a scheme authorising the provision of compulsory care and rehabilitation to individuals with an intellectual disability who have been charged with or convicted of an imprisonable offence.

The Act contains clear statements of the rights of consumers who receive compulsory care and rehabilitation. Safeguards for protecting and giving effect to these rights include the appointment of district inspectors who are appointed from, and carry out a role similar to, district inspectors of mental health under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

District inspectors provide an independent monitoring function to ensure that people subject to the Act have their legal rights respected and upheld. Specific functions include making regular visits to facilities within their jurisdictions, investigating alleged breaches of consumers’ rights or employees’ duties, and assisting with enquiries by High Court judges.

Currently, 13 deputy district inspectors perform this function. They will be confirmed by the Director-General as district inspectors following the election.

Under the Medicines Act 1981

Medicines Adverse Reactions Committee
The Medicines Adverse Reactions Committee (MARC), a discretionary advisory committee established under section 8 of the Medicines Act 1981, advises the Minister on appropriate action to be taken on medicine safety issues. Its secretariat is accommodated within Medsafe.

The MARC meets four times a year to review published material and other reports on adverse reactions, as well as selected reports of significant, unusual or serious reactions reported to the Centre for Adverse Reactions Monitoring at the University of Otago in Dunedin.

The University of Otago is contracted by the Ministry to collect and collate reports on adverse effects of medicines submitted by health care practitioners and the sponsors of medicines. These services are provided by the University through the New Zealand Pharmacovigilance Centre (NZPHVC). The NZPHVC administers two programmes, the Centre for Adverse Reactions Monitoring (CARM) which deals with reports of adverse effects to medicines submitted spontaneously by health care practitioners, and the Intensive Medicines Monitoring Programme (IMMP), which collects data from pharmacies, practitioners and hospitals on a limited number of medicines, (currently three medicines). The aim of the IMMP is to identify, and where possible investigate, possible signals of new adverse effects uncovered from the data it routinely collects.
The Medicines Act requires sponsors of medicines to inform Medsafe, (the New Zealand Medicines and Medical Devices Safety Authority) of all reports of adverse effects they receive. New Zealand has a voluntary reporting system for adverse effects to medicines (including vaccines and blood products), herbal products and dietary supplements for all other healthcare practitioners. New Zealand is very successful and in the opinion of the World Health Organisation has the highest rate and highest quality of reporting per head of population in the world.

The MARC can recommend that Medsafe alert prescribers to an adverse reaction through an article in *Prescriber Update* or via a general letter to prescribers. It can also recommend that the relevant pharmaceutical company update the information in its data sheet about how to use its medicines safely. The MARC can also provide comments to PHARMAC or the relevant health professional body.

The MARC has eight members including the chair, all of whom are appointed by the Minister. The chair is Associate Professor Tim Maling.

**Medicines Assessment Advisory Committee**

The Medicines Assessment Advisory Committee (MAAC) was established in 1984 as a discretionary committee under section 8 of the Medicines Act 1981. Its secretariat is accommodated within Medsafe.

MAAC’s terms of reference are to:

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

MAAC meets four times a year and has up to 12 core members, including the chair (Associate Professor Richard Robson) and four pool members. There are currently 12 core members. All members, both core and pool, are appointed by the Minister.

MAAC also has two sub-committees: the Generic Sub-Committee and the Vaccines Sub-Committee.

**Medicines Classification Committee**

The Medicines Classification Committee (MCC) is a compulsory ministerial committee under section 9 of the Medicines Act 1981. Its secretariat is accommodated within Medsafe.

The MCC recommends to you whether medicines should be classified as prescription medicines, restricted medicines or pharmacy-only medicines. It also reports to you on
any matter concerning the classification of medicines and access to medicines by health professionals and the public.

The MCC has six members, all of whom are appointed by the Minister. The members include two nominees each from the New Zealand Medical Association and the Pharmaceutical Society of New Zealand. The MCC also has two Ministry members, one of whom is required to be the chair. The current chair is Dr Stewart Jessamine.

**Medicines Review Committee**

The Medicines Review Committee (MRC) is a compulsory committee under section 10 of the Medicines Act 1981. Its secretariat is accommodated within Medsafe. The MRC is responsible for reviews of applications for consent to distribute a medicine, and appeals regarding clinical trials, sales of medical devices and licence applications.

The MRC has seven members including the chair, all of whom are appointed by the Minister. The chair is Brian Irvine.

**New Prescribers Advisory Committee**

The New Prescribers Advisory Committee (NPAC) is a discretionary ministerial advisory committee established in May 2001 under section 8 of the Medicines Act 1981. The NPAC advises the Minister on the extension of limited independent prescribing authority to groups of health practitioners. The NPAC also advises on any terms or conditions to be imposed on new prescribers. There is widespread interest in the deliberations and recommendations of the NPAC because the extension of prescribing rights has only recently begun to be implemented.

The NPAC has 17 members including the chair, all of whom are appointed by the Minister. The chair is Associate Professor Margaret Horsburgh.

**Under the Mental Health (Compulsory Assessment and Treatment) Act 1992**

**Mental Health Review Tribunal**

The Mental Health (Compulsory Assessment and Treatment) Act 1992 provides the state with significant powers to deprive people of their liberty should they be found to be mentally disordered and a danger to themselves or others. Accordingly, the Act provides for a District Court Judge to make compulsory treatment orders and for comprehensive procedures of review and appeal of decisions about the patient’s condition and legal status.
The principal role of the Mental Health Review Tribunal (MHRT) is to consider whether or not a patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992 is fit to be released from compulsory status. There is a requirement for every person subject to a compulsory treatment order to have his or her condition reviewed at least every six months. Should a patient disagree with their responsible clinician’s decision that they are not fit to be released from compulsory status, the patient is able to apply to the MHRT for a review of his or her condition. The patient can appeal an MHRT decision to the District Court or High Court.

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

**District inspectors for mental health**

District inspectors are lawyers appointed by the Minister of Health under the Mental Health (Compulsory Assessment and Treatment) Act 1992. District inspectors assist people being assessed or treated under this Act by providing information and ensuring their rights are upheld. In this way, they provide an important safeguard if people are unhappy with the way they are treated under the Act. This watchdog function is performed by district inspectors whether a person is being treated within a psychiatric unit or in the community.

District inspectors are independent from health and disability services. They are neither patient advocates nor legal advisors for the mental health or disability services. District inspectors are required to be detached from the clinical decision-making processes that affect individual patients and care recipients.

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

**Under the New Zealand Public Health and Disability Act 2000**

**Cancer Control Council**

The Cancer Control Council was established in May 2005 under section 11 of the New Zealand Public Health and Disability Act 2000 and is accountable to the Minister of Health. The Council’s key objective is to provide an independent, sustainable focus for cancer control, leading the sector to successfully implement the New Zealand Cancer Control Strategy, of which the key purposes are to:

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

The Council is required to report annually to the Minister of Health and may also advise on any other matters the Minister specifies by notice to the Council.
The Cancer Control Council comprises nine members appointed by the Minister of Health. The Principal Advisor Cancer Control (currently Dr John Childs) also serves as an ex-officio member of the Council. Dame Catherine Tizard is the chair of the Council.

Child and Youth Mortality Review Committee

Section 18 of the NZPHD Act provides for the establishment of mortality review committees that review and report to the Minister on specified classes or types of death. The Child and Youth Mortality Review Committee (CYMRC) was the first such committee established under these provisions.

The CYMRC is responsible for reviewing the deaths of children and young people aged between 28 days and 24 years, with a view to reducing the number of preventable deaths of people in these age groups. The CYMRC has developed a process that securely gathers electronic information from a range of agencies into a central database. This collection of central data assists in reviewing child and youth deaths by collating standard information to support the review.

The CYMRC’s work plan for 2005/06 focuses on the further development of local mortality review processes, engagement with other relevant agencies to inform and connect review processes, and promotion of safety messages.

The CYMRC has 10 members, all of whom are appointed by the Minister. Professor Barry Taylor is the chair of the CYMRC.

Health and disability ethics committees

Health and disability ethics committees (HDECs) undertake ethical reviews of proposed health and disability research and innovative practice in their region of authority. There are seven HDECs: the Multi-region Ethics Committee, two Northern Regional Ethics Committees (based in Auckland and Hamilton), the Central Regional Ethics Committee, two Upper South Regional Ethics Committees (both based in Christchurch), and the Lower South Regional Ethics Committee. These committees were established under section 11 of the NZPHD Act in December 2004, replacing 15 regional ethics committees.

The primary role of HDECs is to safeguard the rights, health and wellbeing of consumers and research participants and, in particular, those persons with diminished autonomy. HDECs were first established in the wake of the 1987 Inquiry into the Treatment of Cervical Cancer and Other Related Matters at National Women’s Hospital (the Cartwright Inquiry), and the 1988 Report on the Cervical Cancer Inquiry.

Each HDEC has 12 members including the chair, all of whom are appointed by the Minister.
Health Workforce Advisory Committee

The Health Workforce Advisory Committee (HWAC) was established in May 2001 as an independent advisory committee under section 15 of the NZPHD Act and reports directly to the Minister of Health. It has a small secretariat accommodated in the Ministry of Health.

The HWAC’s role is to advise the Minister about health workforce issues the Minister specifies by notice to the Committee.

The HWAC’s recommendations, published in 2003, focused on the workforce implications of implementing the Primary Health Care Strategy, health workforce education, building Māori health and Pacific health workforce capacity, promoting a healthy workplace environment, research and evaluation, and the development of the health and support workforce to meet the needs of disabled people.

The HWAC has 11 members including the chair, all of whom are appointed by the Minister. The chair is the Hon Stanley Rodger. The Māori Health and Disability Workforce Sub-Committee, which includes four members co-opted by the HWAC, is chaired by Professor Colin Mantell. The HWAC also has a Medical Reference Group, chaired by Dr George Salmond, which includes seven members co-opted by the HWAC.

National Ethics Advisory Committee

The National Advisory Committee on Health and Disability Support Services Ethics (known as the National Ethics Advisory Committee, or NEAC) was established in 2001 under section 16 of the NZPHD Act. Its statutory functions are to advise the Minister of Health on ethical issues of national significance in respect of any health and disability matters, and to determine nationally consistent ethical standards across the health sector.

The NEAC’s first project was a review of processes for the ethical review of health and disability research in New Zealand. This review resulted in substantial changes to the system of ethical review being implemented in December 2004.

The NEAC is required by statute to report annually to the Minister of Health, and by its terms of reference to agree its work programme in advance with the Minister. The NEAC has 12 members including the chair, all of whom are appointed by the Minister. The chair is Dr Andrew Moore.

National Health Committee

The National Health Committee (NHC) was first established in 1992 and was re-established as a discretionary ministerial advisory committee under section 13 of the NZPHD Act. The NHC is responsible for providing the Minister with advice on the kinds and relative priorities of public health, personal health and disability support services the Committee believes should be publicly funded. It may also advise the Minister on other public health matters. The NHC has a secretariat accommodated within the Ministry of Health.
The NHC has established a Public Health Advisory Committee to advise the Minister about public health issues, including the promotion and monitoring of public health. This committee was established in July 2001 under section 14 of the NZPHD Act.

The NHC has up to 12 members including the chair, all of whom are appointed by the Minister. The chair of the NHC is Dr Robert Logan. Geoff Fougere is the chair of the Public Health Advisory Committee.

**National Health Epidemiology and Quality Assurance Advisory Committee**

The National Health Epidemiology and Quality Assurance Advisory Committee, known as EpiQual, is a compulsory ministerial advisory committee under section 17 of the NZPHD Act. EpiQual first met in March 2004. It is responsible for providing the Minister with advice on any health epidemiology and quality assurance matters, and must specifically examine perinatal, child and adolescent morbidity and mortality issues.

EpiQual’s work programme for 2005/06 focuses on engaging the sector to encourage a shared vision, purpose and language for quality improvement. EpiQual will also assist in the review of the IQ Action Plan, the second action plan supporting the strategy *Improving Quality (IQ): A systems approach for the New Zealand health and disability sector* (published in 2003).

EpiQual has nine members including the chair, Denise Hutchins.

**Perinatal and Maternal Mortality Review Committee**

The Perinatal and Maternal Mortality Review Committee (PMMRC) was established in June 2005 and met for the first time on 5 August. It is the second mortality review committee established under section 18 of the NZPHD Act.

The PMMRC reviews neonatal deaths in the age range from 20 weeks completed gestation (at least 400 grams birthweight) to 28 completed days after birth, and maternal deaths directly related to pregnancy or childbirth, with a view to reducing the number of preventable deaths.

The PMMRC has 10 members including the chair, Professor Cynthia Farquhar; all members are appointed by the Minister.

**Under the Human Assisted Reproductive Technology (HART) Act 2004**

**Advisory Committee on Assisted Reproductive Technology (ACART)**

The Advisory Committee on Assisted Reproductive Procedures and Human Reproductive Research (the Advisory Committee on Assisted Reproductive Technology, or ACART) is established under section 32 of the Human Assisted Reproductive Technology (HART) Act 2004.
Under the HART Act, ACART has several statutory duties and functions, including:

- issuing guidelines and advice to the Ethics Committee on Assisted Reproductive Technology on assisted reproductive procedures or human reproductive research
- providing the Minister of Health with advice on aspects of, or issues arising out of, kinds of assisted reproductive procedure or human reproductive research
- any other function the Minister of Health assigns to ACART by written notice.

ACART is required by statute to report annually to the Minister of Health. ACART currently has 10 members appointed by the Minister of Health. The chair is Professor Sylvia Rumball.

**Ethics Committee on Assisted Reproductive Technology (ECART)**

The Ethics Committee on Assisted Reproductive Technology (ECART) is established and designated under section 27 of the Human Assisted Reproductive Technology (HART) Act 2004. Under the HART Act, ECART has several statutory duties and functions, including:

- considering and determining applications for assisted reproductive procedures or human reproductive research
- keeping under review any approvals previously given, including those applications approved prior to the existence of ECART, and, without limitation, to monitor the progress of any assisted reproductive procedures performed or any human reproductive research conducted under current approvals
- any other functions that the Minister of Health assigns to the Committee by written notice.

ECART currently has eight members appointed by the Minister of Health. The chair is Ms Philippa Cunningham.

**Under the Plumbers, Gasfitters and Drainlayers Act 1976**

**Plumbers, Gasfitters and Drainlayers Board**

The Plumbers, Gasfitters and Drainlayers Board (PGDB) is an independent body corporate whose board members are appointed by the Minister under section 6(2) of the Plumbers, Gasfitters and Drainlayers Act.

The PGDB arranges for the examination and registration of practising tradesmen or those intending to practise plumbing, gasfitting or drainlaying, ensures that tradesmen maintain an adequate level of competence, has disciplinary powers with respect to tradesmen who breach the Act, and performs other functions specified in the Act.

Philip Routhan is the chair of the PGDB.
If reintroduced in the new Parliament, the Energy Safety Review Bill will replace the Plumbers, Gasfitters and Drainlayers Act 1976. The Bill seeks to change the definition of responsible minister, with agency responsibility proposed to fall under the Department of Building and Housing. The Energy Safety Review Bill is being led by the Ministry of Economic Development as it amends the Electricity, Gas and Ministry of Energy Abolition Acts (the responsibility of the Ministry of Economic Development) as well as the Health and Safety Employment Act.

**Under the Radiation Protection Act 1965**

**Radiation Protection Advisory Council**

The Radiation Protection Advisory Council (RPAC) is established under section 5(1) of the Radiation Protection Act. The Director-General of Health and the Director of the National Radiation Laboratory are members, with five further members appointed by the Minister.

The RPAC advises the Director-General on applications for licences to possess irradiating material and devices under the Radiation Protection Act. It also advises the Minister in respect of regulations made under this Act, the exercise of the powers the Act gives to the Minister, and other matters.

Associate Professor Graham Stevens is chair of the RPAC.
Agencies Protecting Patient and Consumer Rights

Several agencies protect and promote the rights of consumers of health and disability support services. Most of these agencies are not formally part of the Minister’s portfolio responsibilities, although the Office of the Health and Disability Commissioner (the Office) has certain reporting duties to the Minister. The Office and other agencies involved in the protection of patient and consumer rights are described in the following section.

Office of the Health and Disability Commissioner

The Office is a Crown entity, which was established under the Health and Disability Commissioner Act 1994, and is an independent Crown entity under the Crown Entities Act 2004. The Office is responsible for promoting and protecting the rights of consumers of health and disability support services as specified in the Code of Health and Disability Services Consumers’ Rights. The Office is also responsible for facilitating fair and simple resolution of complaints.

The Health and Disability Commissioner (the Commissioner) may also, on his or her own initiative, or at the Minister’s request, advise on any matter relating to the rights of health and disability consumers, the administration of the Health and Disability Commissioner Act 1994, or the need for action to give protection to the rights of health and disability consumers.

The Commissioner is appointed by the Governor-General on the recommendation of the Minister of Health. The current Commissioner is Ron Paterson.

Consumer Advocacy Services

The Office operates three health and disability consumer advocacy services: for the Upper North Island, Central and Lower North Island, and the South Island. These services are provided for in Part III of the Health and Disability Commissioner Act 1994, and employ advocates for people who believe there has been a breach of their rights under the Code of Health and Disability Services Consumers’ Rights.

The Office provides funding for the advocacy services. However, the advocacy services are separate bodies and report to a Director of Advocacy, who reports to both the Commissioner and the Minister.
Office of the Ombudsmen

All government agencies, including agencies in the health and disability sector, are subject to the scrutiny of the Office of the Ombudsmen. The Office of the Ombudsmen can investigate any decision or recommendation by a central or local government organisation that affects any person or body of people in their personal capacity. The Office of the Ombudsmen can also review any decisions made by Ministers or government organisations at central, local or regional level in respect of the release of official information. The Office of the Ombudsmen will generally only consider a complaint after an attempt has been made to resolve the matter with the organisation concerned.

The Chief Ombudsmen is Mr John Belgrave.

Office of the Privacy Commissioner

Individuals who believe there has been a breach of their rights under the Privacy Act 1993 can take their complaint to the Office of the Privacy Commissioner. The Privacy Act 1993 promotes 12 information privacy principles relating to the collection, holding, use and disclosure of personal information. The Office of the Privacy Commissioner investigates complaints relating to these principles and promotes acceptance of these principles. The Office also investigates complaints pursuant to the Health Information Privacy Code 1994. Another of the Privacy Commissioner’s functions is to monitor and report on authorised information-matching programmes.

The Privacy Commissioner reports to Parliament through the Minister of Justice. The Privacy Commissioner can also report directly to the Prime Minister on any matter affecting the privacy of an individual.

Marie Shroff is the Privacy Commissioner.

Office of the Human Rights Commission

Consumers of health and disability support services can also complain to the Human Rights Commission if they believe they have suffered unlawful discrimination. Such complaints are pursued under the auspices of the Human Rights Act 1993. Discrimination occurs when a person is treated unfairly or less favourably than another person in the same or similar circumstances. Discrimination is unlawful if it is based on one or more of the 13 types of discrimination specified in the Human Rights Act 1993.

The Chief Human Rights Commissioner is Roslyn Noonan.
Office of the Commissioner for Children

Consumers of health and disability support services can also take any concerns about the treatment of a child to the Office of the Commissioner for Children, which is tasked with promoting the welfare of children and young people and ensuring their rights are recognised. The Commissioner can enquire into any matter affecting children and young people provided the matter has first been investigated by the agency concerned.

Cindy Kiro is the Commissioner for Children.

Families Commission

The Families Commission acts as an advocate for the interests of families generally in a manner that enhances families’ resilience and strengths. The Commission promotes the interests of the full range of families in New Zealand, and promotes better understanding of family issues and needs among government agencies and in the wider community. The Commission’s functions, as outlined in the Families Commission Act 2003, are to:

- encourage and facilitate informed debate about families
- increase public awareness and understanding of matters that affect families’ interests, including the importance of stable relationships (including marriage), the importance of the parenting role, and the rights and responsibilities of parents
- encourage the government to develop policies that promote or serve families’ interests
- consider matters concerning families that any Minister refers to the Commission, and to report and make recommendations on these matters
- promote and stimulate research on families by:
  - collecting and disseminating information or research about families
  - advising on research priorities or gaps
  - contracting for research on families
- consult with or refer matters to other official bodies or statutory agencies.

Dr Rajen Prasad is Chief Commissioner of the Families Commission.
The Provider and Consumer Community

The provider and consumer community is a vital component of the health and disability sector in New Zealand and consists of a diverse range of providers, professional groups, consumer advocates and support groups. The large number of organisations means it is not possible to discuss each, or even the more prominent examples, of these organisations in this document. However, many of these organisations are described in *The Health Sector: The New Zealand directory*, published by Health Sector Publications.

The most common providers are in the primary sector, especially in general practice, pharmacy, nursing and physiotherapy. These providers tend to be privately owned but receive varying degrees of public funding.

The voluntary and support sector is also important. Not-for-profit services are provided by more than 50 national organisations and even more numerous local providers. This group of providers includes some large organisations such as the IHC, Plunket Society, Family Planning Association and Salvation Army.

There is also a range of professional bodies representing groups of providers. Some of these bodies have an important role in contributing to the direction of the sector. The main representative bodies for privately owned providers also have a role in contributing to the direction of the sector.

In recent years community trusts and iwi-based bodies have also become important. Several communities, especially in rural areas, have established community trusts to develop health services for people in their area, and iwi-based organisations are providing an increasing range of health and social services.

Primary Health Organisations

Primary health organisations (PHOs) are the local structures through which DHBs are implementing the 2001 Primary Health Care Strategy. PHOs are not-for-profit organisations funded by DHBs to provide primary health care services for an enrolled population. A PHO will provide services directly by employing staff or through its provider members.

At a minimum, these services include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people’s health when they are unwell. PHOs are required to involve their communities in their governing processes. They must also show that they are responsive to communities’ priorities and needs.

Although primary health care practitioners, such as GPs, are encouraged to deliver services through PHOs, membership is voluntary.

As at 1 July 2005, 3.85 million New Zealanders (of the total population of 4.06 million) belonged to one of the 79 PHOs nationwide.
A PHO Taskforce, comprising members from PHOs, meets every six weeks and gives advice to the Ministry from the PHO perspective. A community council has been established to provide the Ministry with advice on the Primary Health Care Strategy from a consumer/community perspective.
Food-related Agencies

Food regulatory matters have been included in the portfolio responsibilities of the Minister of Health in the past. Information about the two organisations controlling food safety in New Zealand – Food Standards Australia New Zealand and the New Zealand Food Safety Authority – is therefore included in this document.

Food Standards Australia New Zealand

Food Standards Australia New Zealand (FSANZ) replaced the former Australia New Zealand Food Authority on 1 July 2002. FSANZ is unique in that it exercises a degree of supra-national authority by setting rules that apply in both Australia and New Zealand. It is a bi-national organisation working in partnership with the New Zealand Government and Australia’s Commonwealth, state and territory governments.

FSANZ’s prime function will be to develop food standards for adoption in Australia and New Zealand, and then to notify those standards to the Australia and New Zealand Food Regulation Ministerial Council.

New Zealand Food Safety Authority

The New Zealand Food Safety Authority (NZFSA) integrates the food regulatory functions of the Ministry of Agriculture and Forestry (MAF) and the related functions formerly administered by the Ministry of Health. It is a semi-autonomous body attached to MAF. Prior to 1 July 2002 the Ministry of Health was responsible for administering regulations covering food sold within New Zealand, while MAF was responsible for primary production and export food.

NZFSA’s objectives are to:

- administer food safety in the production, processing, distribution, preparation, retail sale and export of food
- ensure a coherent and seamless food regulatory regime across the entire food chain (from production to consumption)
- ensure all food for sale in New Zealand meets the highest standards of food safety and hygiene
- manage the joint food standards treaty with Australia and ensure the interests of New Zealand consumers are protected
- ensure a ‘whole of government’ approach to food-related advice
- negotiate and provide official assurances to overseas governments for food and food-related products
- protect consumers from risks that may arise in connection with the consumption of food, and otherwise protect the interests of consumers in relation to food through effective enforcement and management.
International Aspects of the Sector

The New Zealand health and disability sector is part of a wider international community of such sectors. It is important to maintain contacts with this international community. The advantages of maintaining and developing such contacts include providing New Zealand with the opportunity to:

- share experiences with other countries regarding the organisation, management and delivery of health services
- access best practice approaches and international benchmarks
- assist developing countries
- work with other New Zealand agencies – governmental and non-governmental – that are dealing with issues that impact on health.

The Minister of Health has a central role in developing such contacts.

International contacts

The focus of New Zealand’s official international contacts is the World Health Organization (WHO). The WHO provides or co-ordinates assistance, and in some cases funding, to developing countries to meet a wide range of health needs. The WHO also acts as a forum for debate on such topics as the performance of health systems.

New Zealand’s work with the WHO focuses on a number of initiatives, the most significant being a Framework Convention on Tobacco Control. This framework is designed to reduce global demand for tobacco products. New Zealand is lobbying for alcohol to be the major future focus of WHO work.

The Ministry also acts as a facilitator for WHO fellowships, where developing countries wish to send personnel to New Zealand to improve their policy or operational understanding. New Zealand also contributes to improved health outcomes in developing countries, mostly in the Pacific region, through overseas development assistance funded by NZAID, the New Zealand Agency for International Development.

New Zealand maintains links with the OECD (Organisation for Economic Co-operation and Development), APEC (the network for Asia-Pacific Economic Co-operation), the Commonwealth Fund (a non-government organisation that supports comparative health policy research, based in Washington), and other regional and global organisations. All of these organisations provide New Zealand with an opportunity to influence, contribute to and learn from the international debate on health policies, structures, reforms and practices. These contacts also ensure that international comparative figures and debates are informed by information about New Zealand that is accurate, current and objective.
Contacts with the Commonwealth

New Zealand maintains an active link with health ministers and authorities elsewhere in the Commonwealth. In the past these contacts have included regular Commonwealth Health Ministers Meetings. These deliberations now occur prior to the World Health Assembly in Geneva, Switzerland, in May each year.

Contacts with Australia

There is also a system of regular meetings with Australian ministers of health at the federal, state and territory levels. These contacts take place under the auspices of the Australian Health Ministers’ Conference. This conference provides a forum for ministers to discuss issues of mutual interest and is supported by the Australian Health Ministers’ Advisory Council, made up of chief executives from the states, territories and federal (Commonwealth) Department of Health.

International conventions

A number of United Nations conventions and rules contain implications for, or specific references to, health and disability, such as those governing the rights of the child, women and migrant workers, and initiatives providing for the equalisation of opportunities for disabled people. The Ministry works with the Ministry of Foreign Affairs and Trade and other relevant agencies to ensure that health issues and disability support issues are taken into account.

Alarmed at the projected increase in tobacco-related deaths from 4.5 million presently to 10 million by 2020, the World Health Assembly agreed in 1998 to the negotiation of a Framework Convention on Tobacco Control, an international treaty, WHO’s first to address the issue. New Zealand participated actively in these negotiations. The result was a relatively strong convention covering such issues as tobacco advertising, price and tax measures, and packaging and labelling of tobacco products. The World Health Assembly adopted the negotiated text in May 2003. New Zealand, which already complied with all articles of the treaty except the packaging and labelling requirements, signed the treaty in June 2003 and ratified it in January 2004. The required 40 ratifications were achieved recently and the Framework Convention on Tobacco Control came into force on 28 February 2005.

There is also growing international recognition of the interrelationship between health, the elimination of poverty and sustainable economic development. This is reflected in the recommendations of the WHO Commission on Macroeconomics and Health, and of the United Nations Millennium Declaration. Some health-related topics are also covered in trade agreements, such as the CEP3 Chile/Singapore/New Zealand Closer Economic Partnership, and may also be included in the General Agreement on Trade in Services discussions.
Of most recent significance, in May 2005 the World Health Assembly adopted the new International Health Regulations 2005. These Regulations, which have the effect of a binding international treaty, are the primary international legal framework for preventing and controlling the spread of disease between countries (eg, a SARS outbreak or an influenza-related public health emergency of international concern).

On 15 June 2007, the International Health Regulations 2005 will enter into force for all member states that have not rejected the regulations or successfully lodged reservations. The proposed Public Health Bill, which will replace the Health Act 1956, will be the main statutory instrument for giving effect to our new obligations under the International Health Regulations.

The revised International Health Regulations focus on the early detection and timely response to disease outbreaks and other public health events of potential international significance. As such the Regulations will be the primary legal framework for both the WHO and its 192 member states to assess and respond to emerging international threats to public health, including potential disease pandemics. The adoption by WHO, and implementation by countries such as New Zealand, is a critical part of both emergency preparedness and the routine surveillance and control of communicable disease.
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACART</td>
<td>Advisory Committee on Assisted Reproductive Technologies</td>
</tr>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
</tr>
<tr>
<td>ALAC</td>
<td>Alcohol Advisory Council of New Zealand</td>
</tr>
<tr>
<td>CHFA</td>
<td>Crown Health Financing Agency</td>
</tr>
<tr>
<td>CID</td>
<td>Corporate and Information Directorate (Ministry of Health)</td>
</tr>
<tr>
<td>CYMRC</td>
<td>Child and Youth Mortality Review Committee</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>DHBNZ</td>
<td>District Health Boards New Zealand</td>
</tr>
<tr>
<td>ECART</td>
<td>Ethics Committee on Assisted Reproductive Technologies</td>
</tr>
<tr>
<td>EpiQual</td>
<td>National Health Epidemiology and Quality Assurance Advisory Committee</td>
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<tr>
<td>FSANZ</td>
<td>Food Standards Australia New Zealand</td>
</tr>
<tr>
<td>HART Act</td>
<td>Human Assisted Reproductive Technology Act 2004</td>
</tr>
<tr>
<td>HDECs</td>
<td>Regional Health and Disability Ethics Committees</td>
</tr>
<tr>
<td>HealthPAC</td>
<td>Health Payments, Agreements and Compliance (Ministry of Health)</td>
</tr>
<tr>
<td>HWAC</td>
<td>Health Workforce Advisory Committee</td>
</tr>
<tr>
<td>MAAC</td>
<td>Medicines Assessment Advisory Committee</td>
</tr>
<tr>
<td>MAF</td>
<td>Ministry of Agriculture and Forestry</td>
</tr>
<tr>
<td>MARC</td>
<td>Medicines Adverse Reactions Committee</td>
</tr>
<tr>
<td>MCC</td>
<td>Medicines Classification Committee</td>
</tr>
<tr>
<td>Medsafe</td>
<td>New Zealand Medicines and Medical Devices Safety Authority (Ministry of Health)</td>
</tr>
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<td>MHRT</td>
<td>Mental Health Review Tribunal</td>
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<td>MRC</td>
<td>Medicines Review Committee</td>
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<td>NCSR</td>
<td>National Cancer Screening Register (Ministry of Health)</td>
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<td>NEAC</td>
<td>National Ethics Advisory Committee</td>
</tr>
<tr>
<td>NGOs</td>
<td>non-governmental organisations</td>
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<td>NHC</td>
<td>National Health Committee</td>
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<tr>
<td>NPAC</td>
<td>New Prescribers Advisory Committee</td>
</tr>
<tr>
<td>NZBS</td>
<td>New Zealand Blood Service</td>
</tr>
<tr>
<td>NZFSA</td>
<td>New Zealand Food Safety Authority</td>
</tr>
<tr>
<td>NZHIS</td>
<td>New Zealand Health Information Service (Ministry of Health)</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>--------------</td>
<td>-----------------------------------------------------------</td>
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<tr>
<td>NZPHD Act</td>
<td>New Zealand Public Health and Disability Act 2000</td>
</tr>
<tr>
<td>PGD Act</td>
<td>Plumbers, Gasfitters and Drainlayers Act 1976</td>
</tr>
<tr>
<td>PGDB Board</td>
<td>Plumbers, Gasfitters and Drainlayers Board</td>
</tr>
<tr>
<td>PHARMAC</td>
<td>Pharmaceutical Management Agency</td>
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<td>PHO</td>
<td>primary health organisation</td>
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<td>PMMRC</td>
<td>Perinatal and Maternal Mortality Review Committee</td>
</tr>
<tr>
<td>RHMU</td>
<td>Residual Health Management Unit</td>
</tr>
<tr>
<td>RPAC</td>
<td>Radiation Protection Advisory Council</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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