BEFORE THE WAITANGI TRIBUNAL **WAI 2575**

IN THE MATTER OF	**The Treaty of Waitangi Act 1975**
AND	
IN THE MATTER OF	**The Health Services and Outcomes Kaupapa Inquiry**

EVIDENCE OF JOHN KENNETH HAZELDINE

9 February 2018

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RECEIVED
Waitangi Tribunal
10 Feb 2018
Ministry of Justice
WELLINGTON

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INTRODUCTION

Background

1. I am the Chief Advisor – District Health Board (**DHB**) Funding and Planning, for the Ministry of Health (the Ministry), reporting directly to the Ministry's Director of Service Commissioning.

Structure of this evidence

2. My evidence provides an overview of the current New Zealand health and disability system. This structure has been in place since 2001, when the Ministry became the principal agency responsible for policy advice, funding and monitoring the health and disability sector and district health boards (DHBs) took responsibility for the purchase and provision of health services. **Appendix 1** covers the structural transformations of the New Zealand public health sector since 1983[1].

3. The overview in this evidence is derived in large part from the *The New Zealand Health and Disability System - Handbook of Organisations and Responsibilities* provided within the Ministry's Brief to the Incoming Minister, released in late 2017. I have included additional information specifically for this inquiry, describing in detail the functions of the key health and disability sector organisations responsible for delivering health services and outcomes to all New Zealanders, as well as specific initiatives to acknowledge te ao Māori and improve Māori health outcomes.

4. This evidence builds on my earlier evidence filed with the Waitangi Tribunal on 3 July 2017 (Wai 2575, #A1).

Health and disability services for all New Zealanders

5. The New Zealand health and disability system performs well for most New Zealanders, helping them live longer, healthier and more independent lives.

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[1] https://www.parliament.nz/resource/en-NZ/00PLSocRP09031/9772cc5da74650da549200e3627fef0ef46c5fa7

6. Most New Zealanders engagement with health services is positive, and they enjoy a good standard of health. Despite this, the health of Māori, Pacific peoples and people living in lower socioeconomic areas tends to be worse than the average for New Zealanders generally. Services do not always work well for some of the most vulnerable people, and sometimes miss them entirely. We need to better understand why this happens, and how we can improve our services to meet individual and community needs.

7. The health sector faces both opportunities and challenges as our population continues to age, grow and diversify. We know that we must be future-focused, and continually look for opportunities to improve, promote and protect the health of all New Zealanders.

8. The health and disability system's funding comes primarily from Vote Health, which the Ministry administers. For 2017/18 this totals $16.773 billion. Other significant funding sources include the Accident Compensation Corporation (ACC), other government agencies, local government and private sources, such as insurance and out-of-pocket payments by individuals.

New Zealand's health and disability system is complex and collaborative

9. A complex network of people and organisations deliver the New Zealand health and disability system. This system extends beyond the more visible elements such as the Ministry and DHBs, to include a range of other health related Crown entities, ministerial advisory committees, primary health organisations (**PHOs**), public health units, private providers (including Māori and Pacific providers) and independent general practitioners. The system also encompasses professional and regulatory bodies for all health professionals, including medical and surgical specialties, nurses and other health groups. These people and organisations need to collaborate with each other and across government agencies, local government and communities. Key elements of the system include:

Minister and Ministry of Health

10. The Minister of Health (the Minister), along with Cabinet and the wider government, develops policy for the health and disability sector and provide leadership, supported by the Ministry, and ministerial advisory committees. The Ministry has a range of roles in the system, in addition to being the principal advisor and support to the Minister. The Ministry funds an array of national services (in the order of $2 billion a year, including disability support and public health services), provide clinical and sector leadership and perform a monitoring, regulatory and protection functions.

11. The Ministry uses a population-based funding formula,[23] which allocates the share of funding to each DHB ($12.163 billion in 2016/17) based on the population living in the district – the formula includes adjustors for population age, sex, relative measures of deprivation status and ethnicity (Māori, Pacific and other).

District health boards

12. The 20 DHBs administer most of the day-to-day business of the system, and nearly three-quarters of the funding from Vote Health. They plan, manage, provide and purchase health services for the population of their district, working directly within the community and with local iwi; implement government health and disability policy; and ensure services are effective and efficient for all New Zealanders. DHBs distribute funding for primary health care, hospital services, public health services, aged care services and services provided by non-government health providers, including Māori and Pacific providers.

[2] Further information can be found at https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/accountability-and-funding/population-based-funding-formula

Accident Compensation Corporation

13. ACC funds an important range of health and support services for people suffering from injury resulting from an accident. There are common providers for many services funded by ACC and by DHBs. DHBs provide the majority of emergency and acute services for ACC.

Private health sector

14. There is also a large and strong private health sector in New Zealand. It encompasses private hospitals, private community services, general practices and natural health services. It is financed by health insurance and also directly by consumers in many instances. DHBs also purchase health services (e.g. elective surgery) from private providers from time to time.

Stewardship and leadership of the system

15. The Ministry plays a critical role in system stewardship and leadership. This involves setting a vision, goals and accountabilities for the sector, and working directly with communities, advocates and health practitioners to determine these. In terms of Māori health, this means working directly with Māori health stakeholders, including consumers and health providers to ensure the system is able to effectively respond to their view of good health.

16. The Ministry's stewardship role includes keeping an overview of the whole system and ensuring that the capabilities and connections across organisations work together to collectively deliver a health service that is improving, protecting and promoting the health and wellbeing of all New Zealanders.

17. The Ministry provides leadership across the system, and is the government's primary agent for implementing its health priorities and policies within the system. It also provides leadership to the whole health and disability sector on how to improve health equity[4] in a sustainable and systemic way. It also has a wider role; it coordinates action with other government agencies to deliver on

[4] The World Health Organisation defines equity as the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically.

the government's agenda across the spectrum of social sector services. This includes examining the links between different parts of the system, and strengthening where necessary to support a high-functioning health sector.

18. The Ministry is also responsible for maintaining the regulatory environment and national policy settings that support the sector in providing good quality services for New Zealanders. It works with DHBs and other Crown entities, such as ACC and the Health Quality and Safety Commission, and supports their respective leadership roles.

19. To this end, the Ministry funds, monitors and regulates the performance of DHBs and other health Crown entities. The Ministry seeks to achieve its key functions by working in partnership with other public service agencies and by engaging with people and communities.

Health sector reach

20. New Zealand's health and disability system delivers services through a broad network of organisations. Each organisation has its role in working with others across and beyond the system to achieve better health for New Zealanders, and the ability for individuals and families to live independently.

21. Multiple factors play a role in the health and wellbeing of New Zealanders; in turn, their health and wellbeing have a huge impact on other parts of New Zealanders' daily lives.

Funding health services

22. As above, the Ministry allocates more than three-quarters of the public funds through Vote Health to DHBs. DHBs use this funding to purchase and provide health services for their areas.

23. Independent to this the Ministry spends $2.4 billion to purchase national services. These comprise disability support services, national public health services and national personal health services.

OVERVIEW OF THE NEW ZEALAND HEALTH AND DISABILITY SYSTEM: AS AT FEBRUARY 2018

24. New Zealand's health and disability system is large and complex, with services delivered through a broad network of organisations. The diagram on the following page (**Figure 1**) provides a visual representation of the relationships across and between the various networks of organisations within the New Zealand health and disability system. Each has its role in working with others across and beyond the health and disability system to achieve better health for New Zealanders, and the ability for individuals and families to live independently. Strong collaboration and cooperation across government and non-government agencies, local government, communities, families and whānau are essential to achieving good health, social and economic outcomes.

25. This evidence provides an overview of the health and disability system as at February 2018. It describes the major organisations and structures in the system, along with their roles, functions and responsibilities.

A complex system, working together

26. The Minister of Health (the Minister) with Cabinet and the wider government develops policy for the health and disability sector and provides leadership. The Minister is primarily supported and advised by the Ministry and any ministerial advisory committees the Minister appoints.

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

28. The Ministry has a range of roles in the system, in addition to being the principal advisor and support to the Minister. It funds an array of national

services (including disability support and public health services), provides clinical and sector leadership, and has a number of monitoring, regulatory and protection functions.

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

Stewardship and leadership of the health and disability system

30. The New Zealand Public Health and Disability Act 2000 (NZPHD Act) established the semi-devolved structure of the health system, with the Ministry as the steward of the system.

31. As steward, the Ministry maintains an overview of the whole system in order to lead and shape it to deliver a healthy and independent future for all New Zealanders.

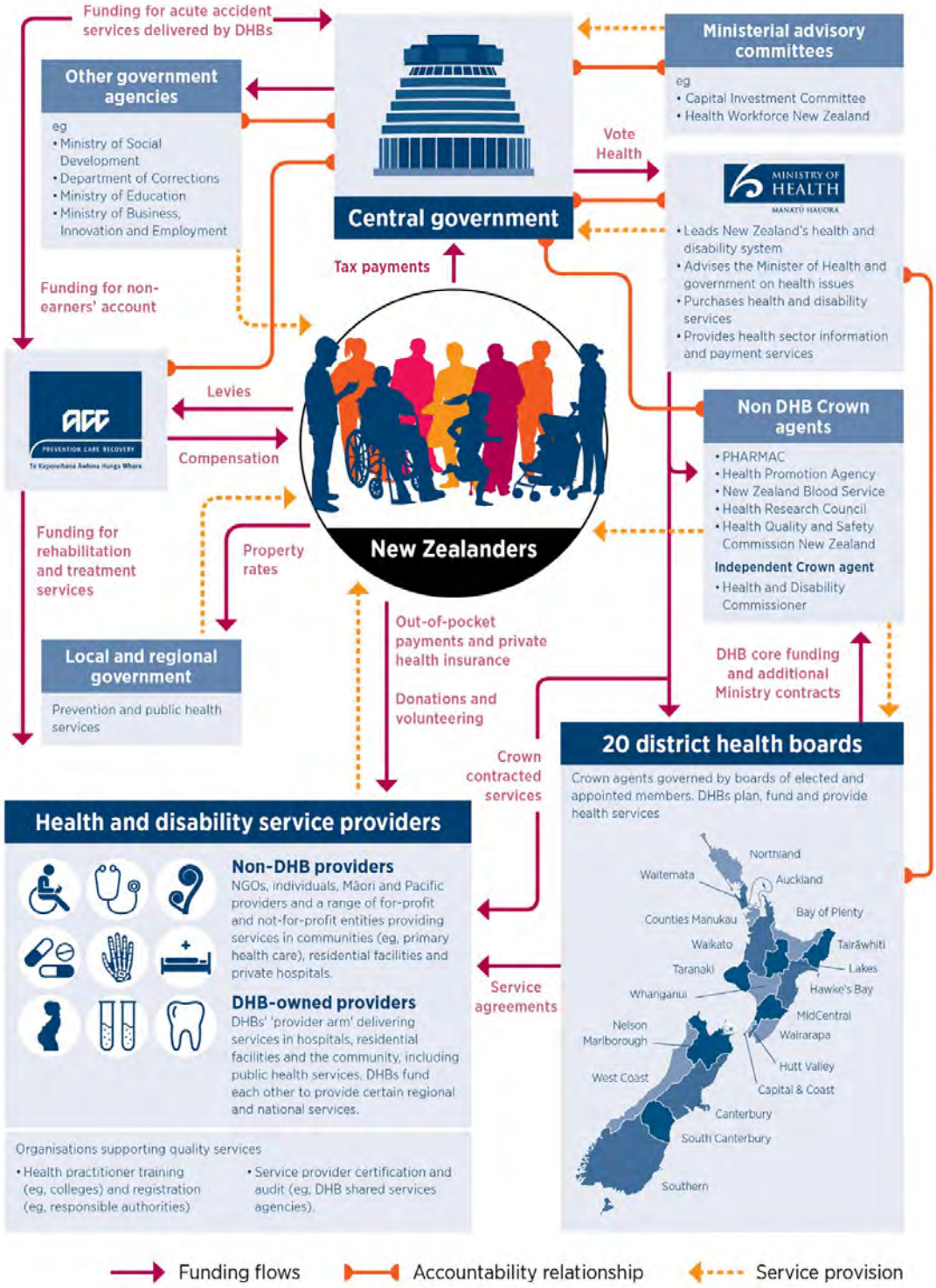
32. The Ministry seeks to achieve this through:

    32.1 advising the Minister, and the government, on health and disability issues;

    32.2 directly purchasing a range of national health and disability support services; and

    32.3 providing health sector information and payment services for the benefit of all New Zealanders.

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


Funding for acute accident services delivered by DHBs
Other government agencies
eg
• Ministry of Social Development
• Department of Corrections
• Ministry of Education
• Ministry of Business, Innovation and Employment
Central government
Ministerial advisory committees
eg
• Capital Investment Committee
• Health Workforce New Zealand
Vote Health
MINISTRY OF HEALTH
MANATŪ HAUORA
• Leads New Zealand's health and disability system
• Advises the Minister of Health and government on health issues
• Purchases health and disability services
• Provides health sector information and payment services
Tax payments
Funding for non-earners' account
ACC
PREVENTION CARE RECOVERY
Te Kaporeihana Awhina Hunga Whara
Levies
Compensation
New Zealanders
Non DHB Crown agents
• PHARMAC
• Health Promotion Agency
• New Zealand Blood Service
• Health Research Council
• Health Quality and Safety Commission New Zealand
Independent Crown agent
• Health and Disability Commissioner
Funding for rehabilitation and treatment services
Property rates
Local and regional government
Prevention and public health services
Out-of-pocket payments and private health insurance
Donations and volunteering
DHB core funding and additional Ministry contracts
20 district health boards
Crown agents governed by boards of elected and appointed members. DHBs plan, fund and provide health services
Northland
Waitemata
Auckland
Bay of Plenty
Counties Manukau
Waikato
Tairāwhiti
Taranaki
Lakes
Whanganui
Hawke's Bay
MidCentral
Nelson
Marlborough
Wairarapa
Hutt Valley
West Coast
Capital & Coast
Canterbury
South Canterbury
Southern
Crown contracted services
Service agreements
Health and disability service providers
Non-DHB providers
NGOs, individuals, Māori and Pacific providers and a range of for-profit and not-for-profit entities providing services in communities (eg, primary health care), residential facilities and private hospitals.
DHB-owned providers
DHBs' 'provider arm' delivering services in hospitals, residential facilities and the community, including public health services. DHBs fund each other to provide certain regional and national services.
Organisations supporting quality services
• Health practitioner training (eg, colleges) and registration (eg, responsible authorities)
• Service provider certification and audit (eg, DHB shared services agencies).
Funding flows
Accountability relationship
Service provision

33. To this end, the Ministry funds, monitors and regulates the performance of DHBs and other health Crown entities. It also provides leadership to the whole health and disability sector on how to improve the health equity[5] in a sustainable and systemic way. The Ministry seeks to achieve its key functions by working in partnership with other public service agencies and by engaging with people and communities.

34. As part of its stewardship role, the Ministry is responsible for steering improvements that help New Zealanders live longer, healthier and more independent lives. This includes both setting a direction for Māori health, which includes working with Māori, and guiding the health and disability sector to improve servicers and outcomes for Māori. Improving Māori health outcomes is both the business and the responsibility of the whole of the sector and this is acknowledged by the sector in its everyday work.

35. The Ministry recognises and respects the principles of the Treaty of Waitangi. The health and disability system engages the principles of the Treaty through:

    35.1 *Partnership* – working with iwi, hapū, whānau and Māori communities to develop strategies for improving Māori health and delivering appropriate health and disability services.

    35.2 *Participation* – involving Māori at all levels of the sector: in decision-making, planning, development and delivery of health and disability services.

    35.3 *Protection* – working to ensure Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices.

36. In order to recognise and respect Treaty principles, and with a view to improving health outcomes for Māori, Part 3 of the NZPHD Act provides

[5] The World Health Organisation defines equity as the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically.

mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

37. In accordance with the Ministry's policy that Māori health is everyone's business, Ministry staff, at all levels of the organisation, are required to exhibit responsiveness to Māori. This requires all staff to understand the role of the Ministry and health and disability sector in achieving health equity and improving health outcomes, including Māori health outcomes; and demonstrate an understanding of the Treaty of Waitangi as it relates to health.

38. In 2016 an executive Māori Leadership role was established to provide strategic leadership and guidance across the Ministry as it works with Māori and health sector stakeholders to improve Māori health outcomes and achieve equity.

Statutory framework

39. The health and disability system's statutory framework is made up of over 25 pieces of legislation. The most significant are the NZPHD Act, the Health Act 1956 and the Crown Entities Act 2004. Legislation the Ministry administers and other regulatory roles are listed in **Appendix 2**.

New Zealand Public Health and Disability Act 2000

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

Health Act 1956

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

Crown Entities Act 2004

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

Funding the health and disability system

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

Vote Health

44. **Appendix 3** shows the components of Vote Health operating expenditure (excluding capital) and Ministry-managed, non-departmental operating expenditure. Other significant funding sources include the ACC, other government agencies, local government, and private sources such as insurance and consumers directly.

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

MINISTER OF HEALTH

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

47. There are various ways the Minister, or the Ministry on the Minister's behalf, can direct activity in the sector. Because it is a semi-devolved system, many day-to-day functions and detailed decisions happen at a local level. Due to the

system's complex set of governance, ownership, business and accountability models, the levers available to the Minister are varied and exert differing levels of control.

Setting the strategic direction

System strategies

48. The Minister is responsible for progressing a number of strategies that provide a framework for the health and disability system. With the support of key health and disability system stakeholders, the Ministry has developed the following system strategies.

Table 1: Strategies relating to the health and disability system[6]

New Zealand Health Strategy	The Minister must determine a strategy for health services: The New Zealand Health Strategy (under the NZPHD Act). The Minister must report each year on progress in implementing the Strategy. If the Strategy is reviewed, the Act requires consultation with appropriate organisations and individuals. Improving health outcomes for Māori is an acknowledged priority within the strategy.
New Zealand Disability Strategy	The Minister for Disability Issues must determine a strategy for disability services: the New Zealand Disability Strategy (under the NZPHD Act). The Minister for Disability Issues must report each year on progress in implementing the Strategy. If the Strategy is reviewed, the NZPHD Act requires consultation with appropriate organisations and individuals. The development of the New Zealand Disability Strategy was supported by a Revision Reference Group and members of the public, including Māori with disabilities (tāngata whaikaha) and Māori service providers. The New Zealand Disability Strategy acknowledges the principles of the Treaty of Waitangi and the importance of cultural identity for tāngata whaikaha in how they live their lives in both te ao Māori and te ao Pākehā. *Whaia Te Ao Marama* Further to the New Zealand Disability Strategy, the Ministry has developed Whaia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Services. Whaia Te Ao Mārama establishes priority areas of action for achieving the aspirations of tāngata whaikaha and their whānau, and for reducing barriers that may impede better outcomes.

[6] New Zealand Health Strategy http://www.health.govt.nz/publication/new-zealand-health-strategy-2016

New Zealand Disability Strategy http://www.odi.govt.nz/nz-disability-strategy/

He Korowai Oranga: Māori Health Strategy https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga

Primary Health Care Strategy https://www.health.govt.nz/publication/primary-health-care-strategy

Healthy Ageing Strategy https://www.health.govt.nz/our-work/life-stages/health-older-people/healthy-ageing-strategy-update/healthy-ageing-strategy-implementing-strategy

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing https://www.health.govt.nz/publication/ala-moui-pathways-pacific-health-and-wellbeing-2014-2018

	Te Ao Mārama is a group of external advisors that supports the implementation of Whāia Te Ao Mārama and provides advice to the Ministry on issues that affect tāngata whaikaha. The group includes tāngata whaikaha and Māori who work within the sector.
He Korowai Oranga: Māori Health Strategy	He Korowai Oranga: Māori Health Strategy sets the overarching framework to guide the government and the health and disability sector to achieve the best health outcomes for Māori. He Korowai Oranga means 'the cloak of wellness'. The Strategy was refreshed in June 2014, expanding the aim of He Korowai Oranga from whānau ora to pae ora – healthy futures. He Korowai Oranga acts as a catalyst for increasing Māori participation across the whole health and disability system and has played a pivotal role in shifting the health and disability system from focussing on disease and illness to a desire for health and wellness.
Primary Health Care Strategy	The Primary Health Care Strategy was developed in 2001 to provide a clear direction for the future development of primary health care in New Zealand. Although now somewhat dated, it remains a useful document that outlines the specific contributions primary health care makes to improving health outcomes.
Healthy Ageing Strategy	The Healthy Ageing Strategy was published in 2016 and presents the strategic direction for change and a set of actions to improve the health of older people, into and throughout their later years. The Strategy refreshed and replaced the Health of Older People Strategy (2002) and aligned it with the New Zealand Health Strategy.
'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018	'Ala Mo'ui has been developed to facilitate the delivery of high-quality health services that meet the needs of Pacific peoples. It sets out the strategic direction to address health needs of Pacific peoples and stipulates actions, which will be delivered from 2014 to 2018. This edition builds on the successes of the former plan from 2010-2014. The Ministry publishes reports on implementation progress periodically.
Other strategies in the health sector	There are a number of additional health strategies that guide specific areas of work in the health sector (e.g. Cancer Control Strategy, Suicide Prevention Strategy).

Ministry's Statement of Strategic Intent

49. The Minister is responsible for approving the Ministry's Statement of Strategic Intent. The Statement of Strategic Intent[7] states the strategic objectives that the Ministry intends to achieve or contribute towards.

Ensuring a high performing system

50. Beyond setting the system's strategic direction, the Minister is responsible for the performance of DHBs and other health-related Crown entities (see below). The Ministry is responsible for monitoring these entities on behalf of the Minister, and for providing regular advice to the Minister on their

[7] http://www.health.govt.nz/publication/statement-intent-2015-2019

performance. DHBs and other health Crown entities are accountable to government through the Minister.

51. The Minister has a range of ways through which to discharge these responsibilities:

Setting Crown entities' strategic direction and annual performance requirements

52. The Minister sets the performance expectations of a Crown entity through an annual Statement of Performance Expectations. This lays out the outcomes and objectives that the entity intends to achieve over the coming year which will in turn be captured again through its annual report to Parliament.

53. A Crown entity's Statement of Intent sets out the strategic objectives the entity intends to achieve or contribute to. The Minister can require amendments or a new Statement of Intent.

54. Depending on the nature of the specific Crown entity and its governing Act, the Minister may be able to give a direction on government policy, such as the Eligibility Direction, which describes the group of people who are eligible for publicly-funded (i.e. free or subsidised) health and disability services in New Zealand.[8] The Minister can also recommend that a whole of government direction be given by the Ministers of State Services and Finance jointly to support whole of government approaches.

Monitoring strategic direction and results

55. Active monitoring of a health Crown entity's performance ensures that the contributions of the entity are aligned with the government's intentions and the contributions of other participants in the health system. It provides early warning of any issues that need resolving. The Ministry is responsible for the day-to-day administration and monitoring of Crown entities on behalf of the Minister.

[8] http://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/eligibility-direction

56. The Minister can request information on performance and operations at any time, review performance and operations at any time, and ask the State Services Commissioner to act on issues (under the State Sector Act 1988).

Board appointments, remuneration and removals

57. The Minister recommends appointments and reappointments to the boards of health Crown entities (including the chair). How this works depends on the specific type of Crown entity, nonetheless the Minister is central to these appointments.

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

Other key roles of the Minister under legislation

Health emergencies

59. The Minister has the power to declare health emergencies under the Health Act 1956. This has the effect of unlocking various emergency powers for statutory officers across the sector, such as medical officers of health. Health emergencies include major national events, such as the Canterbury earthquakes, and the impact of global events such as the H1N1 influenza pandemic in 2009.

60. The Prime Minister, in consultation with the Minister, has the power to issue an epidemic notice under the Epidemic Preparedness Act 2006, which allows a broader range of possible responses.

Health inquiries

61. The Minister also has the power under the NZPHD Act to order inquiries into the funding or provision of health and/or disability support services, the management of DHBs or other health Crown entities established under the

NZPHD Act, or act on a complaint or matter that has arisen. The Minister also has power to establish government inquiries under the Inquiries Act 2013. For example, the recently-announced Mental Health and Addictions Inquiry to take place in 2018.[9]

Responsibilities under mental health legislation

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

63. The Minister makes approximately 60 decisions annually on matters such as extended leave from hospital, and eventual change of legal status, for special and restricted patients (i.e. patients who enter secure mental health services via the courts after committing a serious criminal offence or by transfer from prison when in need of compulsory treatment).

64. The Minister also appoints district inspectors and members of the Mental Health Review Tribunal.

MINISTRY OF HEALTH

65. The Ministry is the government's principal agent in the New Zealand health and disability system and has overall responsibility for the stewardship of that system. This involves keeping an overview of the whole system and ensuring that the capabilities and connections across organisations work together.

66. The Ministry acts as the Minister's principal advisor on health policy, thereby playing an important role in supporting effective decision-making. At the same time, the Ministry has a role within the health sector as a funder, monitor, purchaser and regulator of health and disability services.

[9] See the relevant Cabinet paper: https://www.dia.govt.nz/diawebsite.nsf/Files/Government-Inquiry-into-Mental-Health-and-Addiction/$file/Establishing-the-Government-Inquiry-into-Mental-Health-and-Addiction.pdf

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

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

Purpose and role

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

    69.1 its stewardship and leadership of New Zealand's health and disability system;

    69.2 advising the Minister and the government on health and disability issues;

    69.3 directly purchasing a range of national health and disability support services; and

    69.4 providing health sector information and payment services for the benefit of all New Zealanders.

70. The Ministry works both with other public sector agencies and the health sector more widely and engages with people and their communities in carrying out these roles.

Stewardship and leadership

71. The Ministry leads the health and disability system, and has overall responsibility for the stewardship and leadership of that system. It steers

improvements that help New Zealanders live longer, healthier and more independent lives.

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

72.1 funds, monitors and drives the performance improvements of DHBs and other health Crown entities;

72.2 supports the planning and accountability functions of DHBs and other health Crown entities; and

72.3 regulates the sector and ensures legislative requirements are being met.

Advising the Government

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

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

Purchasing health and disability services

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

75.1 public health interventions (e.g. immunisation);

75.2 disability support services;

75.3 elective services (medical or surgical services);

75.4 screening services (e.g. cervical screening);

75.5 mental health services; and

75.6 maternity services.

75.7 ambulance services.

76. All service agreements between the Ministry and health and disability service providers require providers to meet the diverse needs of Māori and align with government policies and strategies for Māori health.

77. The Ministry also works with other social sector agencies, such as the Ministry of Social Development and the Ministry of Education, to improve the accessibility and appropriateness of universal and targeted services, strengthen capacity and practice on the front line, as well as better understand the needs of Māori to tailor services and target investment.

78. The Ministry and NGOs have a formal relationship outlined in the *Framework for Relations between the Ministry and Health and Disability NGOs*[10]. This relationship is facilitated by an NGO Health & Disability Council and an NGO relationship manager in the Ministry.

Framework for Relations between the Ministry and Health and Disability NGOs

79. The *Framework for Relations* is a statement of the commitment of the Ministry and health and disability NGOs to put strong and respectful relationships between the parties into practice. It is not intended to be a legally binding document. It is more appropriately described as a "written handshake". Its authority is derived from endorsement by the Ministry and the NGOs through a process of active consultation and joint development.

80. NGOs include independent community, and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is

[10] https://ngo.health.govt.nz/resources/ministry-health-publications/framework-relations

distinct from both government and the market. The framework recognises the vital contribution of unpaid workers in society, and the important role of NGOs in helping them to make that contribution through the direct provision of health and disability services (particularly disability support services, mental health services and Māori health services).

81. A strong and respectful relationship between the Ministry and health and disability NGOs will provide a mutual benefit where there is a shared understanding of the knowledge, skills and expertise within NGOs, and an understanding of each other's values, goals and strategies.

82. The relationship requires effective mechanisms that will provide opportunities for regular communication and feedback, meaningful consultation, building of knowledge, and NGO participation in developing and evaluating policy.

Universal services

83. The Ministry funds and purchases universal health services and public health initiatives that are delivered to the whole population. Universal services are services available to all New Zealanders, regardless of means or need, and are important mechanisms for ensuring everyone is able to participate fully in society.

84. There are a number of mechanisms in place to improve access to primary health care services for all New Zealanders, including Māori, such as:

    84.1 Zero Fees for Under Thirteens scheme – aims to improve access to healthcare for primary and intermediate school children by removing cost barriers;

    84.2 Very Low Cost Access (VLCA) scheme – a government subsidy for general practices with an enrolled population of 50 per cent or more high needs patients (Māori, Pacific or NZ deprivation decile 9-10) where the practice agrees to maintain patient fees at a low level; and

84.3 Care Plus – coordinates a comprehensive approach to improve outcomes for high needs patients, including lower cost access tied to the individual rather than the practice.

Maternity services

85. New Zealand's maternity service is one such example of a universal health service. Almost all pregnant women receive primary maternity care prior to birth with the majority of this care being provided through a Lead Maternity Carer (LMC). Registration with a LMC is less common among Māori women, however, particularly in the first trimester of their pregnancy. Accordingly, there is less take up in the level of universal maternity services received by Māori.

86. To address these disparities in maternity services, DHBs have developed innovative ways of supporting pregnant women with complex health and social needs including taking an integrated approach to health and social services. An integrated approach means utilising health and social services to provide an efficient, person-centred continuum of care pathway that recognises and meets the needs of women throughout pregnancy, childbirth and the postnatal period, and children (0-6 years), and families across the different levels of the health system.

87. For example, the Maternity Quality Initiative is the Ministry's programme for driving coordinated, continuous improvement in maternal and infant health across the maternity sector and beyond. It was launched in 2011 and originated from the Maternity Action Plan developed by an advisory group to the government in 2008 and 2009.

88. Following sector consultation in early 2015, the Maternity Quality Initiative was refocused by the previous Minister of Health to the following four priorities:

88.1 strengthening primary maternity services, including more timely and more equitable access to community based primary maternity care and support;

88.2 better support for women and families who need it most, including better health and social support for young mothers and for maternal mental health, and support for improving health literacy among vulnerable populations;

88.3 embedding maternity quality and safety, including further support for local clinical leadership and review, and meeting the Ministry's Maternity Standards obligations; and

88.4 improving integration of maternity and child health services, including improving transition between services through improved coordination, service configuration and information technology.

89. The Ministry is supporting DHBs to learn from this initiative and consider how government agencies can better work together to wrap services around consumers across maternal and child health services and social services within their own regions.

Other universal health services

90. Further examples of universal health services include primary health care and Well Child Tamariki Ora services.

Progressive universal services

91. DHBs and third party providers also deliver a range of services that are a hybrid mix of universal and targeted interventions.

92. An example of a progressive universal service is New Zealand's universal child health and development service – the Well Child Tamariki Ora programme. Well Child Tamariki Ora providers deliver support to parents and whānau to ensure healthy development through the first five years of a child's life. Through scheduled Well Child Tamariki Ora checks, tamariki and their whānau can be referred to specialist or targeted services.

93. Equity is a core principle of Well Child Tamariki Ora and all performance measures include monitoring by ethnicity and deprivation. The Ministry has allocated additional funds to DHBs to ensure the programme targets families, including Māori whānau, who are less likely to engage with health services.

Targeted services

94. DHBs also provide targeted services to a limited group of people. The following examples demonstrate the early intervention services delivered by DHBs that are targeted to certain priority populations or areas.

Screening Support Services

95. The Ministry funds a range of screening services. In order to address inequalities in access, it provides extra support for priority group women (including Māori) to attend breast and cervical screening appointments. For example, the National Cervical Screening Programme provides funding to DHBs to be passed onto primary health care providers for free smears to priority group women.

96. Other ways to improve breast and cervical screening coverage for wāhine Māori are:

96.1 data matching with primary care to identify eligible wāhine Māori who are not enrolled in screening programmes or are overdue for their cervical screen or screening mammogram;

96.2 regional collaboration across all providers involved in the screening pathway;

96.3 monitoring provider initiatives and sharing successes with other providers; and

96.4 social marketing initiatives, for example a new "Time to Screen website" and Facebook page.

The Rheumatic Fever Prevention Programme

97. The Rheumatic Fever Prevention Programme is another example of a preventative service that targets at-risk population groups. The programme funds the six DHBs with the highest incidence of rheumatic fever in Māori to target Māori children and young people aged four to 19 years and their families.

98. The programme has actively encouraged the involvement of Māori health providers at a local level. Additionally, DHBs are required to consult with Māori stakeholders and communities in the development of rheumatic fever prevention plans.

Healthy Families NZ

99. Healthy Families NZ prevention platform operates in ten locations. These are areas with higher-than-average rates of risk factors for preventable chronic disease and/or high levels of deprivation.

100. The initiative is bringing community leadership together in a united effort for better health. It aims to improve people's health where they live, learn, work and play, in order to prevent chronic disease. Healthy Families NZ has an explicit focus on improving Māori health and reducing inequalities for groups at increased risk of chronic diseases.

101. Māori participation and leadership is at all levels of the planning and implementation of Healthy Families NZ. Four of the ten Healthy Families NZ locations are led by Māori organisations, and senior Māori and Pacific leaders are involved in the governance arrangements for all Healthy Families NZ locations.

Immunisation target

102. Ten years ago, immunisation coverage for tamariki Māori was significantly below that of other New Zealand children at around 50 per cent. The immunisation target explicitly addressed equity as a core part of the programme. Over the last ten years, national immunisation coverage at 12

months of age for all ethnic groups in New Zealand is equivalent, at 95 per cent coverage.

Māori health providers

103. The Ministry funds Māori health providers to deliver a range of national health services including Health Workforce Training and Development, National Elective Services and National Maternity Services.

104. DHBs are the primary funders of Māori health providers. Under the NZPHD Act DHBs have a responsibility to support Māori involvement in service delivery. Most DHBs demonstrate this through a wide range of service contracts to Māori health providers. The majority of services delivered by Māori health providers are targeted towards Māori, Pacific and high-need communities, with a kaupapa and delivery framework which is distinctively Māori.

105. The Ministry is committed to increasing the capacity and capability of Māori providers to deliver effective health and disability services for Māori. Highlights include:

105.1 funding of $270.3 million in 2015/16 to Māori health providers by the Ministry and DHBs, an increase of $14.4 million (or 5.6 per cent) since 2011/12.

105.2 increased funding by the Ministry to Māori health providers by $2.6 million (or 2.8 per cent) between 2011/12 and 2015/16. This is higher than the percentage increase in the Ministry's non-departmental expenses for the same period (2.0 per cent).

105.3 an increase of DHB funding to Māori health providers by $11.8 million (or 7.2 per cent) between 2011/12 and 2015/16.

Māori Provider Development Scheme

106. Māori health and disability service providers are supported by the Māori Provider Development Scheme which provides annual grant funding[11] for organisational development support, enabling them to continue to develop effective health services; and financial assistance to students undertaking health related tertiary studies through the Hauora Māori Scholarships.

Rongoā Māori

107. The Ministry works with Māori traditional healing practitioners to support rongoā Māori within the health and disability sector. For a number of years the Ministry has worked with rongoā whānau – including traditional healers and Māori health providers – to determine the role of traditional healing in mainstream services.

108. In this context, the Ministry also funds providers across the country to deliver rongoā Māori (traditional healing) services. These services include mirimiri (massage), karakia (pastoral support) and whitiwhiti kōrero (cultural support).

109. All Ministry-funded rongoā providers are required to adhere to the 2014 rongoā standards, *Tikanga ā-Rongoā*. These standards[12], designed to improve the quality of rongoā services, were developed in 2014 following a series of hui with rongoā practitioners across Aotearoa.

110. In December 2011, a new independent national rongoā governance body – Te Kāhui Rongoā Trust – was established to protect, nurture and promote rongoā Māori. The Ministry has provided funding through the Māori Provider Development Scheme for establishing the governance body. However the Ministry does not currently fund the Trust. It is optional for rongoā practitioners to be a part of Te Kāhui Rongoā Trust.

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[11] 2013/14 to 2016/17 Māori Provider Development Scheme funding amounts for Māori providers by DHB and national Māori organisations are presented at http://www.health.govt.nz/publication/maori-provider-development-scheme-mpds-funding-information-2013-14-2016-17. Annual amounts for Hauora Māori Scholarships are also included. All amounts are GST exclusive.

[12] https://www.health.govt.nz/system/files/documents/publications/tikanga-a-rongoa-english-apr14-v2.pdf

Information and payments

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

111.1 the provision of national information systems (for example PRIMHD[13] and immunisation register); and

111.2 a payments service to the health and disability sector (totalling $7.5 billion of Ministry and sector payments made per annum; around 1.8 million claims).

Statutory positions

112. The following statutory positions exist within the Ministry.

Director-General of Health

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

113.1 powers relating to the appointment and direction of statutory public health officers, oversight of the public health functions of local government, and authorising the use of special powers for infectious disease control under the Health Act 1956;

113.2 certifying providers under the Health and Disability Services (Safety) Act 2001; and

[13] PRIMHD (pronounced 'primed') is a Ministry of Health single national mental health and addiction information collection of service activity and outcomes data for health consumers. More information is available at http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data

113.3 issuing guidelines under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and other Acts.

114. The Director-General is also the Psychoactive Substances Regulatory Authority under the Psychoactive Substances Act 2013. This role is currently delegated to the Group Manager, Medsafe, and the Manager, Psychoactive Substances, Medsafe. Medsafe is the New Zealand Medicines and Medical Devices Safety Authority and is a business unit of the Ministry.

Director of Mental Health

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

116. The Director's functions and powers under the Act allow the Ministry to provide guidance to mental health services, supporting the strategic direction provided in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*[14] and a recovery-based approach to mental health. The Deputy Director of Mental Health is required to perform such duties as the Director may require. The Deputy Director is also the Ministry's Senior Advisor, Mental Health.

Director of Public Health

117. The position of Director of Public Health is provided for in the Health Act 1956. The Director of Public Health has the authority to independently advise the Director-General and Minister on any matter relating to public health. The Director also provides national public health professional leadership, and

[14] http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017

professional support and oversight for district medical officers of health. The Deputy Director of Public Health assists the Director of Public Health in carrying out both statutory and non-statutory responsibilities.

Executive Leadership Team

118. The Ministry's Executive Leadership Team is responsible for the Ministry's strategic management, corporate governance and organisational performance. It supports the Director-General of Health by:

118.1 setting the Ministry's strategic direction and priorities within the context of the government's policy objectives for the health and disability system;

118.2 ensuring that the Ministry delivers on its strategies and goals by allocating resources, including purchasing health and disability services, monitoring the performance of organisations and accounting for the use of publicly-funded resources;

118.3 ensuring that the Ministry has the capacity and capability to meet the Government's objectives, including having the people, information, structures, relationships, resources, culture and leadership to fulfil Government direction in the medium and long term; and

118.4 supporting the Director-General of Health's financial and operational delegations by providing advice on key matters of health and disability public policy and implementation.

Clinical leadership roles within the Ministry

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

Chief Medical Officer

120. The Chief Medical Officer provides support and advice on clinical matters to the Director-General of Health and other key stakeholders, clinical leadership and direction, and expert input into health services planning.

Chief Nursing Officer

121. The Chief Nursing Officer provides expert advice on nursing to government, provides professional leadership to the nursing profession, and ensures an effective New Zealand contribution to nursing and health policy in international forums (e.g. the World Health Organisation) and a close association with Australian colleagues (through the Australian and New Zealand Council of Chief Nurses).

MINISTERIAL ADVISORY COMMITTEES

122. From time to time the Minister may establish a ministerial advisory committee to provide expert advice on specific subject matter areas, and offer a forum for representatives of the sector to have a role in decision-making. Such committees are provided for under section 11 of the NZPHD Act.

National Ethics Advisory Committee

123. Under section 16 of the NZPHD Act, the Minister must appoint a national advisory committee on health and disability support services ethics. Known as the National Ethics Advisory Committee it provides advice to the Minister on ethical issues and determines nationally consistent ethical standards across the health and disabilities sector.

Health Workforce New Zealand

124. Health Workforce New Zealand is a ministerial advisory committee established under sections 11 and 15 of the NZPHD Act. It advises the Minister and the Director-General of Health on the performance of the Ministry's Health Workforce unit, which aims to ensure that the New Zealand public has a health care workforce fit to meet its needs. Its work includes supporting and funding workforce development initiatives, and financial support for

postgraduate programmes and schemes to target hard-to-staff communities and specialties.

Other ministerial advisory committees

125. Further ministerial advisory committees provide advice to the Minister, including:

125.1 four National Health and Disability Ethics Committees (northern A, Northern B, Central and Southern), whose function is to secure the benefits of health and disability research by checking that it meets or exceeds established ethical standards to safeguard the rights, health and cultural wellbeing of consumers and research participants. The legal basis for the National Health and Disability Ethics Committees can be found in section 16 of the NZPHD Act.

125.2 the Ethics Committee on Assisted Reproductive Technology (ECART), which considers and determines applications for assisted reproductive procedures, extending the storage period of gametes and embryos, reviews assisted human reproductive research, and reviews and monitors the progress of approvals

125.3 the Advisory Committee on Assisted Reproductive Technology issues guidelines and advice to ECART and provides advice to the Minister on assisted reproductive procedures and human reproductive research.

126. Additional information on the above committees, and details of other advisory committees and health sector bodies, are provided in **Appendix 4**.

CROWN ENTITIES

127. Under the Crown Entities Act 2004, Crown entities fall within five broad categories

127.1 statutory entities (i.e. Crown agents, autonomous Crown entities and independent Crown entities);

127.2 Crown entity companies;

127.3 Crown entity subsidiaries (i.e. companies controlled by Crown entities);

127.4 school boards of trustees; and

127.5 tertiary education institutions.

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

Table 2: Health portfolio Crown entities

Type	Entity
Crown agents Crown agents must give effect to policy that relates to the entity's functions and objectives if directed by the Minister. The Minister appoints board members and has the power to remove a board member from office at his or her discretion.	District Health Boards (20)
	Health Promotion Agency
	Health Quality & Safety Commission
	Health Research Council of New Zealand
	New Zealand Blood Service
	Pharmaceutical Management Agency (PHARMAC)
Independent Crown entity Independent Crown entities are not subject to government policy directions unless specifically provided for in another Act. Board members are appointed by the Governor-General on the advice of the Minister, and may be dismissed by the Governor-General for 'just cause', on the advice of the Minister, in consultation with the Attorney-General.	Health and Disability Commissioner

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

Board appointments to Crown entities

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

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

Accountability and performance

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

Annual Letter of Expectations

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

Enduring Letter of Expectations

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

Statement of Intent and Statement of Performance Expectations

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

Output Agreement

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

Annual Report

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

Directions

Policy directions

137. The Minister may give one or more Crown entities a direction on Government policy relating to the entity's functions and objectives. Crown agents must 'give effect to' policy directions, and autonomous Crown entities must 'have regard to' them. The Minister cannot give an independent Crown entity a policy direction unless this is specifically provided for in an Act.

Whole of government directions

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

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

DHB-specific directions

140. The Minister has additional direction-giving powers under the NZPHD Act in respect of DHBs, as below.

Crown agents

District health boards

141. There are currently 20 DHBs. DHBs are responsible for implementing the health policies of the Government, and for providing or funding the provision of health services in their districts. The role, responsibilities and accountabilities of DHBs are set out in some detail below.

Health Promotion Agency

142. The Health Promotion Agency was formed on 1 July 2012 through the merger of the Alcohol Advisory Council of New Zealand and the Health Sponsorship

Council. The Health Promotion Agency also incorporated some health promotion functions delivered by the Ministry.

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

144. The Health Promotion Agency is funded from Vote Health, the levy on alcohol produced or imported for sale in New Zealand, and part of the problem gambling levy. It employs 91 full-time equivalent staff (FTE) with 2 FTE Māori-specific roles.

145. The Health Promotion Agency developed the *Te Hiringa Hauora* strategic framework in early 2015, which sets out four key focus areas for improving the effectiveness of its work with and for Māori:

145.1 Te Pou Matauranga (capacity development) – developing the capacity and capability of Health Promotion Agency staff to work effectively with Māori communities. It also includes a focus on the development of Māori community capacity to undertake health promotion activities at a local level.

145.2 Te Pou Mahi Ngātahi (strategic relationships) – collaborating with iwi and Māori organisations to improve health promotion outcomes for Māori. This includes kaupapa-specific work in delivering Health Promotion Agency programmes as well as looking at broader wellbeing approaches.

145.3 Te Pou Kōrero (communication) – ensuring health promotion resources and messages are relevant and culturally appropriate for supporting improved health for Māori. The Health Promotion Agency does this through consumer research with Māori.

145.4 Te Pou Rangahau (research and information) – working with Māori researchers to support and grow Māori research and ensure the Health Promotion Agency approach to data collection, analysis and dissemination increases the effectiveness of Māori research.

Health Quality & Safety Commission

146. Established in December 2010, the Health Quality & Safety Commission (HQSC) provides advice to the Minister on how quality and safety in health and disability support services may be improved, and is responsible for determining and reporting quality and safety indicators (such as significant events). It also has a range of functions relating to mortality, including appointing and supporting mortality review committees.

147. There were 68.4 FTE working at HQSC as of 30 December 2017. Māori health quality advancement is largely staffed by employees tasked with other roles, but one executive leadership team member is 0.2 FTE assigned to Māori Advancement.

148. In 2010, the Commission has developed the New Zealand Triple Aim [then known as the National Health Board] for quality improvement, which commits to:

148.1 improved health equity for all populations;

148.2 improved quality and safety of care for people and their whānau; and

148.3 best value for public health system resources.

149. The Commission's goal is to support and equip its staff, expert advisory groups and committees to recognise inequity for Māori, and to systematically address inequity in the planning and implementation of programmes.

150. Te Roopū Māori, the Commission's Māori strategic advisory board, gives support and guidance to the Commission's Board and chief executive. It includes Māori health experts and advisors (including consumer representation).

151. The Commission also uses a Māori advancement framework, Te Whai Oranga, to support the achievement of the best possible outcomes for Māori. Te Whai Oranga is supported by the Kaiwhakahaere Te Whai Oranga, who ensures the implementation of the framework.

Health Research Council of New Zealand

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

152.1 health and wellbeing in New Zealand – keeping New Zealanders healthy and independent for longer;

152.2 improving outcomes for acute and chronic conditions – understanding, prevention, diagnosis and management of acute and chronic conditions;

152.3 New Zealand health delivery – improving service delivery; and

152.4 rangahau hauora Māori – improving Māori health outcomes and quality of life.

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

expectations. As of June 30, there are 30: employees 21 FTE and 9 part-time equivalent (PTE).

154. The Health Research Council outlines in its statement of intent its focus on achieving health equity through increased investment in, and new opportunities for, Māori health research and researchers, by providing:

154.1 a broad spectrum of career development awards to Māori researchers to ensure that they have the skills and experience to compete for this funding;

154.2 ring-fenced funding for Māori health research;

154.3 guidelines on the conduct of Māori health research that require that applicants formally address responsiveness to Māori in research proposals.

155. The Health Research Council's *Vision Mātauranga Capability Fund* also supports research contracts that unlock the science and innovation potential of Māori knowledge, resources and people for the environmental, economic, social and cultural benefit of New Zealand. The fund supports Ngā Kanohi Kitea research contracts, which provide support for iwi, hapū and Māori community groups to focus on a community-identified health need.

New Zealand Blood Service

156. The New Zealand Blood Service (NZBS) ensures the supply of safe blood products. It provides an integrated national blood transfusion process, from the collection of blood from volunteer donors to the provision of blood products within the hospital environment. This work is undertaken with a workforce of 523 FTE. There are no specific Mori roles within the operational staff. The NZBS is funded through the sale of blood products to DHBs.

157. The NZ Blood Service's Māori Responsiveness Strategy provides a strategic framework to identify areas where it can progress its approach to benefit Māori. The Service works together with iwi, hapu, whānau and Māori

organisations to encourage blood donation, while acknowledging and safeguarding Māori cultural concepts and values.

Pharmaceutical Management Agency

158. PHARMAC has a legislative objective under section 47 of the NZPHD Act to secure for eligible people in need of pharmaceuticals the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided. PHARMAC manages the pharmaceutical schedule which applies consistently across New Zealand, and decides which medicines, therapeutic medical devices and related products are publicly funded, who can prescribe them and who can access them.

159. PHARMAC manages a fixed budget, called the Combined Pharmaceutical Budget, which is determined on an annual basis by the Minister after receiving advice from PHARMAC and DHBs. The Combined Pharmaceutical Budget value for 2016/17 was $849.6 million. PHARMAC's framework for considering and making decisions on funding pharmaceuticals, *Factors for Consideration*,[15] includes active considerations of the health needs of Māori.

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

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

162. PHARMAC's main roles include:

[15] https://www.pharmac.govt.nz/medicines/how-medicines-are-funded/factors-for-consideration/

162.1 managing the pharmaceutical schedule, including determining eligibility and criteria for the provision of subsidies;

162.2 managing incidental matters, including in exceptional circumstances providing for subsidies for the supply of pharmaceuticals not on the pharmaceutical schedule;

162.3 engaging in research to meet its objectives; and

162.4 promoting the responsible use of pharmaceuticals.

163. PHARMAC acknowledges the disproportionate underrepresentation of Māori in access to key pharmaceuticals, and on its role within the medicines system to influence these outcomes and achieve the goals of *Te Whaioranga 2013 - 2023, PHARMAC's Māori Responsiveness Strategy*[16].

164. PHARMAC's Māori Responsiveness Strategy, *Te Whaioranga,* contains the following ten-year strategies:

> **Advance tino rangatiratanga with whānau in health interventions**
>
> *Te Whaioranga* recognises the desire by Māori to have control over their own health and wellbeing, and seeks to support Māori through encouragement; empowerment, facilitation and service based on respect, trust and shared mutual purposes.
>
> **Establish and maintain authentic strategic connections**
>
> Strategic stakeholder engagement and authentic communication is core to what we do. We will work with partners in pursuit of mutual purposes. Our strength is our ability to make linkages between different groups in the health sector, across sectors and with various community groups. Current programmes such as One Heart Many Lives and He Rongoā Pai, He Oranga Whānau are examples of communities in action. We will invest in strengthening communities through encouraging flexibility, creativity and innovation. This will enable us to do more in an enhanced way.
>
> **Champion evidence based Māori medicine management**

[16] https://www.pharmac.govt.nz/maori/te-whaioranga-maori-responsiveness-strategy/

> Strengthening the evidence base relating to Māori use of medicines is a way that PHARMAC can make a positive contribution to Māori health. By prioritising key Māori health priority areas ensures that the area of greatest need is appropriately targeted.
>
> **Support and engage in indigenous research and development about pharmaceutical management**
>
> PHARMAC has contributed to empowering Māori communities through the transfer of knowledge that is meaningful to communities. There is potential to further explore research and development opportunities in understanding pharmaceutical management and to share this.
>
> **Enhance and enable internal expertise and capability in te ao Māori**
>
> PHARMAC staff must have the competence to work in both worlds – te ao Māori and te ao Pākehā. A unique skill set is required in order to advance tino rangatiratanga with whānau. This unique skill set needs to be supported with on-going professional development and support in both worlds.

165. PHARMAC's Māori Responsiveness strategy also states:

> As part of these strategies, PHARMAC will work together with Māori communities and the wider health sector in pursuit of common purposes to both:
>
> - further and better identify differences in access to medicines treatment by Māori, or their use, that cannot be explained by factors such as demographics and disease burden, and which are specific and remediable; and then
> - reduce those differences where PHARMAC can (within PHARMAC's funding role and the funding provided).

166. PHARMAC, as part of its decision-making process, as outlined in *Te Whaioranga,* considers the effect of its decisions on addressing health disparities, including those experienced by Māori, and on Māori health outcomes in general, in accordance with PHARMAC's commitment to the Treaty of Waitangi.

Independent Crown entities

Health and Disability Commissioner

167. The Health and Disability Commissioner Act 1994 allows for the establishment of a Health and Disability Commissioner. The Health and

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

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

Crown-owned companies

NZ Health Partnerships

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

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

171. Examples of the Ministry's work include:

Collective Insurance:

172. Collectively DHBs own assets valued at approximately $15 billion. On behalf of DHBs and other associated entities, NZ Health Partnerships facilitates the best insurance deal available to them on a collective basis.

173. By working together the sector offers insurers a portfolio that is geographically spread with a high level of risk identification and management processes in place. Substantial cover is gained as a result from a comparatively low premium, than if each DHB were to insure on its own. Without the collective, some DHBs (notably Canterbury DHB) would not be able to secure insurance cover.

174. In 2016/17 Collective Insurance Service cover for all 20 DHBs was obtained for material damage business interruption (MDBI), liability package, motor vehicle, travel, and personal accident. The coverage was obtained from insurers in New Zealand, Australia, the UK, Singapore and China.

Shared Banking:

175. NZ Health Partnerships manages shared banking and treasury services on behalf of DHBs and associated subsidiaries. DHBs derive benefits from streamlined transactional banking services, cash management and little or no working capital facility fees.

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

177. An example of collaboration is health sector procurement.

178. In 2015, NZ Health Partnerships led an extensive consultation on procurement with DHBs, PHARMAC, the Ministry of Business Innovation and Employment (MBIE) and others. This process led to a number of precedents being set: the sector's first-ever DHB Procurement Strategy was approved by all 20 DHB Chief Executives (April 2016); a sector-wide procurement governance model was established (May 2016); and the sector's first ever agreed Procurement Operating Model was unanimously approved by DHB Chief Executives (March 2017).

179. The Operating Model covers the approach, functions and roles of various organisations. It is split into the following broad classifications:

179.1 **MBIE** – syndicated sourcing, government rules of sourcing and government direction.

179.2 **PHARMAC** – pharmaceutical and medical device procurement managed by PHARMAC on behalf of the sector (increasing over time).

179.3 **NZ Health Partnerships** – national procurement services for DHBs

179.4 **Collaborative** – procurement categories / opportunities that include several DHBs.

179.5 **Local** – procurement categories / opportunities conducted at a local level by an individual DHB.

180. Sector-wide procurement governance is overseen by the Joint Procurement Authority which includes DHB CEOs and the CEOs of NZ Health Partnerships (Chair) and PHARMAC, the General Manager Government Procurement for MBIE, a leading New Zealand clinician and other DHB leaders.

DISTRICT HEALTH BOARDS

181. There are currently 20 DHBs in New Zealand spread across four regions. DHBs are responsible for implementing the health policies of the Government, and for providing or funding the provision of health services in their districts. DHBs fund PHOs to provide essential primary health care services to their populations. Public hospitals are owned and funded by DHBs (and a list of these can be seen at **Appendix 5**).

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

182.1 improving, promoting and protecting the health of people and communities;

182.2 promoting the integration of health services, especially primary and secondary care services;

182.3 seeking the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional and national needs; and

182.4 promoting effective care or support of those in need of personal health services or disability support.

183. Other DHB objectives include:

183.1 promoting the inclusion and participation in society, and the independence, of people with disabilities; and

183.2 reducing – with a view to eliminating – health disparities by improving health outcomes for Māori and other population groups.

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

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

186. The four regions are:

186.1 **Northern** – Northland, Waitematā, Auckland and Counties Manukau DHBs.

186.2 **Midland** – Waikato, Lakes, Bay of Plenty, Tairāwhiti and Taranaki DHBs.

186.3 **Central** – Hawke's Bay, Whanganui, MidCentral, Hutt Valley, Capital & Coast and Wairarapa DHBs.

186.4 **South Island** – Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern DHBs.

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

Table 3: DHB populations and 2017/18 funding

DHB	Population	2017/18 funding
Northland	175,220	$561.9 million
Waitematā	615,340	$1460.3 million
Auckland	530,460	$1248.9 million
Counties Manukau	551,390	$1368.7 million
Waikato	411,520	$1136.4 million
Lakes	108,320	$312.8 million
Bay of Plenty	233,590	$691.9 million
Tairāwhiti	48,430	$160.2 million
Taranaki	118,965	$334.6 million
Hawke's Bay	163,580	$480.9 million
Whanganui	63,270	$217.6 million
MidCentral	175,880	$492.5 million
Hutt Valley	147,520	$383.6 million
Capital & Coast	311,670	$733.8 million
Wairarapa	44,135	$134.8 million
Nelson Marlborough	148,370	$416.9 million
West Coast	32,600	$127.8 million
Canterbury	558,830	$1369.5 million
South Canterbury	60,040	$176.4 million
Southern	324,090	$844.2 million

Figure 2: District Health Board boundaries

Shared services agencies and subsidiaries

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

188.1 Alliance and Northern Regional Alliance (Northern region);

188.2 HealthShare (Midland region);

188.3 Technical Advisory Services (Central region); and

188.4 South Island Alliance (South Island region).

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

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

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

Board appointments to DHBs

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

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

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

performance. A commissioner was appointed to Southern DHB in June 2015. Her term is due to end in 2019, to coincide with local body elections.

195. The NZPHD Act provides for mechanisms to enable Maori to contribute to decision-making on, and to participate in the delivery of, health and disability services. In Particular:

195.1 Section 29(4) provides that in making appointments to a board, the Minister must endeavour to ensure that—

(a) Maori membership of the board is proportional to the number of Maori in the DHB's resident population (as estimated by Statistics New Zealand); and

(b) in any event, there are at least 2 Maori members of the board.

195.2 Schedule 3 has specific provisions concerning training of DHB board members, as follows:

> (1) A board that has elected or appointed to it a member or members not already familiar with the obligations and duties of a member of a board, Māori health issues, Treaty of Waitangi issues, or Maori groups or organisations in the district of the DHB concerned must fund and, to the extent practicable, ensure the member or members undertake and complete, training approved by the Minister relating to whichever of those matters the member or members are not familiar with.
>
> (2) Any such board must keep an up-to-date record of the following matters:
>
> (a) the name of each member of the board:
>
> (b) the date on which each member of the board most recently came into office as a member of the board:
>
> (c) any familiarity each member of the board has at that date with the obligations and duties of a member of a board, Maori health issues, Treaty of Waitangi issues, and Maori groups or organisations in the district of the DHB concerned:
>
> (d) the nature of the training (if any) the board is required by subclause (1) to fund and, to the extent practicable, have any of its members undertake and complete:
>
> (e) the date that training was completed or, if it is still in progress, the date on which it started and the date by

> which it is expected to have been completed or, if it has not yet started, the date on which it is expected to start.
>
> (3) A board asked by the Minister to give him or her a copy of the record must comply with that request as soon as practicable, and no later than 5 working days after the request.

Accountability

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

Government expectations

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

Annual Letter of Expectations

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

Enduring Letter of Expectations

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

Accountability documents

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

Statement of Intent

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

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

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

Statement of Performance Expectations

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

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

Crown Funding Agreement

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

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

Operational Policy Framework

208. The Operational Policy Framework is a set of business rules, policies and guideline principles that outline the operating functions of DHBs. The Operational Policy Framework is one of the schedules to each Crown Funding Agreement and is updated annually. A full copy of the Operational Policy Framework can be found at **Appendix 8**[17].

209. Paragraph 3.10 of the Crown Funding Agreement *Operational Policy Framework* sets out the obligations DHBs have to improve Māori health. Specifically paragraph 3.10 provides:

> 3.10.1 It is one of the explicit purposes of the NZPHD Act 'to reduce health disparities by improving the health outcomes of Māori';
>
> 3.10.2 Each DHB (in both its funder and provider functions) must aim to reduce health disparities by improving health outcomes for Māori;
>
> 3.10.3 Each DHB must provide relevant information, including ethnicity data, to Māori to enable Māori to participate in, and contribute to, strategies for Māori health improvement;
>
> 3.10.4 Each DHB (in both its funder and provider functions) must establish and maintain processes to enable Māori to participate in, and contribute to, strategies designed to improve the health of Māori. These processes include developing effective relationships with iwi and Māori, consultation with Māori, as well as service delivery and monitoring;
>
> 3.10.5 Each DHB must foster the development of Māori capacity for participating in the health and disability sector, and for providing for the needs of Māori. This work includes contributing to Māori provider and workforce development and improving access to, and the effectiveness of, mainstream services for Māori, cultural competency training and a focus on health literacy.

[17] The document is also available at http://nsfl.health.govt.nz/accountability/operational-policy-framework-0/operational-policy-framework-201617

> 3.10.6 Each DHB must aim to achieve health equity between various population groups within New Zealand, including Māori, by developing and implementing services and programmes, in consultation with Māori.

Service Coverage Schedule

210. The Service Coverage Schedule sets out the national minimums for the range and nature of health services to be funded by DHBs. For some services the Service Coverage Schedule also covers subsidies and user charges, as well as specific quality and audit requirements. The Service Coverage Schedule is another schedule to the Crown Funding Agreement and is updated annually. (The Service Coverage Schedule 2017/18 can be seen at **Appendix 7**.)

Annual Report

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

211.1 a statement of service performance;

211.2 an annual financial statement for the DHB;

211.3 any direction given to the DHB by the Minister;

211.4 the amount of remuneration paid to DHB board members and employees in the year; and

211.5 an audit report, produced on behalf of the Auditor-General.

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

Quality Accounts

213. Quality Accounts are a means by which health care providers account for the quality of the services they deliver, just as financial accounts show how an organisation uses its money. Quality Accounts are being adopted in New

Zealand and are produced annually by DHBs, with guidance from the Health Quality & Safety Commission.

214. The accountability cycle timetable, showing how the various government expectations, planning documents and accountability documents fit together, is set out in **Table 4** below.

Table 4: Accountability cycle for DHBs

1 February	Crown Funding Agreement variations signed by both parties (inclusion of new service schedules).
March/May	Drafts of the Annual Plan, with Statement of Intent (SOI), as required, and the Statement of Performance Expectations (SPE) and Regional Service Plan are provided to the Minister (via the Ministry). The Minister (via the Ministry) provides feedback.
1 May	Crown Funding Agreement variations signed by both parties (roll-overs of existing service schedules).
June	The final Annual Plan, with SOI, as required, the SPE and the Regional Service Plan are provided to the Minister for approval.
30 June	End of financial year.
As soon as practicable	DHBs publish the Annual Plan with SOI, as relevant, and the SPE. The Minister presents the DHB SOI, as required, and the SPE to the House of Representatives. When the SOI falls due for tabling once every three years, the Minister can present the Annual Plan containing the component SOI and the SPE, or the SOI and SPE can be presented as stand-alone documents.
1 July	Crown Funding Agreement variations signed by both parties (inclusion of new service schedules).
1 October	Crown Funding Agreement variations signed by both parties (inclusion of new service schedules).
November	DHBs must produce an Annual Report following the end of the financial year. A final, board-approved Annual Report for the preceding financial year must be provided to the Minister no later than mid-November. This is also the last opportunity for DHB SOIs and SPEs for the current year to be tabled, if they have not been already. Draft Letter of Expectations is prepared for the Minister.
December	DHBs publish their Quality Accounts on their website and submit these to the Health Quality & Safety Commission. DHBs may wish to publish their Quality Accounts as part of their Annual Report. Minister's Letter of Expectations is sent to DHB chairs.

Planning documents

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

Annual Plan

216. Each DHB agrees with the Minister on an Annual Plan. This plan sets out how the DHB delivers health services locally to meet Government priorities, with a focus on health equity, and how this can be provided in a financially

responsible manner and in line with the DHB's role and functions. DHBs also previously produced Māori Health Plans each year to set out how the DHB planned to reduce health disparities between Māori and non-Māori. Māori health performance measures have been incorporated into DHB Annual Plans in 2017/18 and the focus on equity has been strengthened in these plans.

217. DHBs are required to include actions in their annual plans that describe how they will meet the obligations in paragraph 3.10 of the Operational Policy Framework and achieve health equity between population groups. This requires DHBs to consider the characteristics of the current and future population of their respective districts.

218. Specific actions to achieve health equity and by area of health focus may include health condition-specific activities and actions to resolve inequities of access to and utilisation of health services more generally. For each identified action, DHBs are required to provide clear intervention logic outlining how the proposed action will lead to improved health outcomes for priority populations.

219. To improve the health of Māori, DHBs are required to include appropriate equity actions for Māori for every priority area. Priority areas are determined by the Minister based on his or her view of the most pressing sector challenges and the commitments and manifesto of the Government, and in turn will have been consulted in their development. The priority areas for DHB planning are set by the Minister through an annual letter of expectations to DHBs. Some aspects of this letter are personalised for individual DHBs. A generic version of the letter for 2017/18 is provided at **Appendix 6** and also available on the National Service Framework Library website.[18]

220. Some examples of Māori equity actions in priority areas include:

[18] https://nsfl.health.govt.nz/

220.1 *Living Well with Diabetes* – a self-management education programme tailored for Māori to reduce inequity in the proportion of Māori and non-Māori with diabetes.

220.2 *Māori Model of Care for Mental Health* – a revised Māori Model of Care for Mental Health that is flexible, clinically effective and culturally responsive to the needs of Māori clients and is integrated across the system.

220.3 *Bowel Screening Equity review* – new waiting time initiatives with reporting by ethnicity in order to review inequitable outcomes for population groups.

DHB Planning priorities

221. The priority areas that form annual planning performance expectations for DHBs are determined directly by the Minster. Draft planning guidance for DHBs is provided on a publicly accessible website[19] (see also **Appendices 9a, 9b, 9c**). The Ministry consults widely on how implementation of the priorities is reflected in DHB planning documents and receives feedback from DHBs, NGOs, PHOs and specific sector groups such as the National Reference Group of Māori Health Strategy Managers within DHBs, Tumu Whakarae[20]. A planning workshop day is held to help facilitate sector input.

222. The annual planning advice for 2017/18 included the following guidance:[21]

Extract from DHB Annual planning guidance – Health Equity in DHB Annual Plans:

[19] https://nsfl.health.govt.nz/dhb-planning-package/201718-planning-package

[20] The Kaupapa of Tumu Whakarae is to 'bring together the collective experience of members to further a shared goal that Māori health gain stays on the national agenda and that as a national Roopū can provide some of the required leadership'.

[21] Note that the 2017/18 Regional Service Plan Guidelines include the Health Equity expectations for Regional Service Plans.

DHBs are expected to consider and include actions in their APs that will help them to achieve health equity for all of their populations, including Māori. Specific actions to achieve health equity will vary by DHB and by area of health focus. This may include condition specific activity, but should also include actions to resolve inequities of access to and utilisation of health services more generally. Effective, patient-centred, universal services, as well as tailored or targeted interventions, will be required to achieve health equity.

DHBs should consider the characteristics of the current and future population of the district, including demography, socioeconomic determinants, health status and demand for health services within their district, when identifying areas of focus for health equity. To support this outcome ensure you consider appropriate equity activities for Māori where appropriate.

Equity actions need to be clearly identified within the AP. Therefore, please include the code "EOA" for "equitable outcomes action" immediately following any action that is specifically designed to help reduce health equity gaps. It is expected that there will be an equity focus for every priority area.

DHBs report progress in delivery of the plans on either a quarterly or six monthly basis depending on the priority area. The Ministry has a structured web based feedback process in place for each deliverable. Summary reports are provided to the Minister each quarter, these reports are also shared with DHBs Chairs and Chief Executives and central government agencies.

Extract from DHB regional planning guidance - Health Equity Tools:

Actions vary depending on the understanding of the equity issues of the priority area. The following tools, or others at your disposal, can be used to assess and identify regional disparities and outline activities for achieving health equity.

- Equity of Health Care for Māori: A Framework (this was recently released in July 2014).
- Whānau Ora Health Impact Assessment 2007.
- The Health Equity Assessment Tool: A User's Guide 2008.

> The Ministry has recently released DHB Māori Health Profiles 2015, which can help identify areas of focus for planning to improve equity.
>
> To facilitate the delivery of high-quality health services that meet the needs of Pacific people, 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018 has been developed. The Ministry publishes six-monthly progress reports on its website.

Reporting on annual plans

223. DHBs report progress in delivery of the annual plans on either a quarterly or six-monthly basis, depending on the priority area. The Ministry has a structured web-based feedback process in place for each deliverable. Summary reports are provided to the Minster each quarter. These reports are also shared with DHBs Chairs and Chief Executives and central government agencies.

Regional Service Plan

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

Performance

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

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

Financial performance

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

Non-financial performance

Health targets

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

Quarterly summaries

229. Quarterly summary reports provide an overview of DHB performance against expectations. These consolidated reports present an at-a-glance snapshot of DHB performance against expectations across a range of key markers as at 30 September, 31 December, 31 March and 30 June. Performance measures previously associated with Māori Health Plans are now included in the quarterly summary reports from quarter one 2017/18.

District alliances

230. District alliances are local partnerships between health providers, organisations and funders. All DHBs must be members of an alliance.

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

232. For example, the Canterbury Clinical Network[22] is the broadest health alliance in New Zealand with 12 partner organisations, which have signed the District Alliance Agreement, committing to work together for the people of Canterbury with whole of system engagement. Partners to the alliance include not only the Canterbury DHB and PHOs, but also pharmacy, laboratory, radiology and community service providers, providing clinical input from across the wider system.

System Level Measures

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

[22] http://ccn.health.nz/Home.aspx

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

234.1 reduce Ambulatory Sensitive Hospitalisation rates per 100,000 for 0 – 4 year olds;

234.2 reduce acute hospital bed days per capita;

234.3 patient experience of care (inpatient and primary care surveys);

234.4 reduce amenable mortality rates;

234.5 proportion of babies living in a smoke-free household at six weeks post-birth; and

234.6 youth health measure.

DHB-specific directions

235. Under the NZPHD Act, the Minister can give a DHB specific directions. These are in addition to the policy direction and whole of government direction provisions in subpart 1 of Part 3 of the Crown Entities Act 2004. For example, the Minister may:

235.1 give DHBs directions that specify the persons who are eligible to receive services funded under the NZPHD Act (i.e. the Health and Disability Services Eligibility Direction 2011);

235.2 require DHBs to provide or arrange for the provision of certain services;

235.3 state how administrative, support and procurement services within the public health and disability sector should be obtained; and

235.4 direct DHBs to comply with stated requirements for the purpose of supporting government policy on improving the effectiveness and efficiency of the public health and disability sector.

Funding and services

236. DHBs exist within a funding environment where:

236.1 there is a mix of funding models (i.e. capitation, fee-for-service, pay-for-performance and individualised funding), and a range of financial and non-financial incentives. The Ministry also contracts directly with providers of some services, such as disability support and some maternity services;

236.2 a population-based funding formula determines the share of funding to be allocated to each DHB, based on the population living in the district. The formula includes adjustors for population age, sex, relative measures of deprivation status and ethnicity (Māori, Pacific and other);

236.3 DHBs are responsible for making decisions on the mix, level and quality of health and disability services, within the parameters of national strategies and nationwide minimum service coverage and safety standards; and

236.4 the Ministry, as the Minister's agent, defines nationwide service coverage, safety standards and the operating environment. The Minister enters into funding agreements with DHBs and may exercise reserve powers in the case of repeated performance failure (i.e. appointing a Crown monitor to, or dismissing, the DHB board).

237. Funding to DHBs ($12.163 billion in 2016/17) is distributed using the population-based funding formula,[23] which allocates funding based on the size and composition of each DHB's population. This means the share of funding each DHB receives is largely determined by whether (and by how much) its population is growing or shrinking relative to others. Statistics New Zealand provides updated DHB populations annually for use in setting DHB funding shares. The population-based funding formula has been used to allocate funding to DHBs since 2003/04.

238. In general, DHBs have flexibility in the allocation of funding to specific services, and over service volumes, to reflect the needs of their populations. However, with regard to mental health services, a specified amount of DHB funding has been set aside for this client group.

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

240. DHBs pay an additional lump sum to the tertiary hospitals[24] to compensate them for the higher costs of maintaining specialist tertiary capability and access. The national prices for inter-district flows and the tertiary adjuster are calculated annually in a joint project between the Ministry and DHBs.

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[23] Further information can be found at https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/accountability-and-funding/population-based-funding-formula

[24] Hospitals with in-patient care with advanced equipment for surgery or investigation.

Māori Participation

DHB-Māori relationships

241. To date, DHB-iwi relationships have been the primary mechanism for relationship-based engagement with Māori in the health sector. Under section 23 of the NZPHD Act, DHBs are responsible for establishing and maintaining processes that enable Māori to participate in and contribute to strategies for Māori health improvement.

242. Although it is left to individual DHBs to determine how they will give effect to this requirement, all DHB have established formal arrangements with local Māori within their regions. In all of these formal arrangements Māori have established a relationship entity to engage with DHBs. Comprising representatives from local iwi and Māori communities, these entities frequently act as an advisory committee to the DHB Board itself.

243. The role of these Māori entities varies across DHBs and is most commonly agreed in a Memorandum of Understanding. These typically set the expectations for the relationship between the parties, including the level at which the Māori entity is likely to be involved such as to provide advice, guidance and assistance to support DHBs in achieving their objectives. In some cases additional provisions to monitor DHB progress in achieving their annual plans might also be included

244. Some examples of current DHB arrangements in place include:

244.1 Bay of Plenty DHB, which has established a shared governance relationship instrument known as the Bay of Plenty DHB Rūnanga. The DHB Rūnanga provides input and direction to the Bay of Plenty DHB on all strategic matters affecting health and disability services for Māori at a governance level.

244.2 Northland DHB, which has a Memorandum of Understanding with He Mangai Hauora mo te Waka a Taonui

- Māori Health Gains Council. The council provides guidance to the board on any factor the council believes may adversely affect the health status of Northland Māori and how the board can improve the health status of Northland Māori.

244.3 Southern DHB, which has a principles of relationship agreement with Kā Rūnaka - Iwi Governance Committee. The committee provides advice and makes recommendations to the Southern DHB regarding Māori health.

Māori health providers

245. Under the NZPHD Act, DHBs have a responsibility to support Māori involvement in service delivery. DHBs are required to foster the development of Māori capacity to participate in the health and disability sector and to provide for the needs of Māori.

246. Most DHBs demonstrate this through a wide range of service contracts with Māori health providers. These service contracts make the biggest contribution to the ability of a Māori health provider to operate in a viable and sustainable way, and support Māori involvement in service delivery.

247. Māori providers are key players in improving access to effective and appropriate health and disability services for the whole community, developing services and delivery frameworks which are distinctively Māori.

Employment relations

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

249. Collective bargaining is the primary means of setting pay and conditions in DHBs. Thirteen national or near-national multi-employer collective agreements cover approximately 65 per cent of all DHB employees, while seven regional multi-employer collective agreements cover a further 20 per

cent. The balance of DHB employees are covered by local collective or individual employment agreements. In addition, there are three collective agreements with the New Zealand Blood Service.

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

Role of the Ministry in employment relations

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

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

252.1 monitor local, regional and national bargaining;

252.2 liaise with and provide information, advice and feedback to the Minister and the Minister of State Services, other government agencies and DHBs; and

252.3 advise and report to Cabinet, if required.

Health Sector Relationship Agreement

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

OTHER RELEVANT OFFICER HOLDERS, ORGANISATIONS AND NETWORKS

Statutory officers

Public health statutory officers

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

Mental health statutory officers

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

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

Primary health organisations

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

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

259. PHOs can identify as Māori PHOs, with six Māori PHOs currently operational. A Māori PHO is defined as an organisation that is owned, governed and operated by iwi and/or Māori organisation/s.

Accident Compensation Corporation

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

Non-government organisations

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

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

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

Public health units

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

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

Local authorities

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

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

Clinical networks

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

268.1 accelerated chest pain pathways in DHBs. These pathways speed up the diagnostic process for patients with chest pain without compromising patient safety; and

268.2 telestroke services, which connects stroke patients at smaller hospitals with specialists via video link to be managed more quickly and closer to home.

269. The following is a broad sample of clinical networks:

Major Trauma National Clinical Network

270. The Major Trauma National Clinical Network provides clinical leadership and oversight to support a planned and consistent approach to the provision of major trauma services across New Zealand.

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

National Stroke Network

272. The National Stroke Network's objective is to facilitate equitable access and improve outcomes for stroke survivors and their families and whānau, through

the implementation of best practice set out in the New Zealand Clinical Guidelines for Stroke Management 2010.

New Zealand Cardiac Network

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

National Cardiac Surgery Clinical Network

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

Adolescent and Young Adult Cancer Network Aotearoa

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

National Child Cancer Network

276. The National Child Cancer Network provides advice, recommendations and action plans on specific areas of service delivery (e.g. fertility preservation) and shares information, knowledge and best practice across the country.

National Child and Youth Clinical Network

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

Regional cancer networks

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

INTERNATIONAL LINKS

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

279.1 protect New Zealand against international health threats;

279.2 learn from other countries' experiences and international debate on ways to organise, manage and deliver health services, including best practice and innovations; and

279.3 provide support and assistance to less developed countries, particularly in the Pacific region, recognising that health in Pacific nations strongly affects the health of people in New Zealand.

International contacts

World Health Organisation

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

281. New Zealand also maintains links with the Organisation for Economic Cooperation and Development, Asia–Pacific Economic Cooperation, the Commonwealth Fund (an NGO based in Washington D.C., USA that

conducts comparative health policy research), and other regional and global organisations.

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

The Commonwealth

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

Australia

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

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

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

Pacific links

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

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

International conventions

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

290. The Ministry is working with Te Puni Kōkiri on the cross-agency work plan to implement the United Nations Declaration on the Rights of Indigenous Peoples Declaration. Te Puni Kōkiri is in the initial stages of this work.

World Health Organisation Framework Convention on Tobacco Control

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

International Health Regulations

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

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

United Nations Sustainable Development Goals

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

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

CONCLUSION

296. This overview of the New Zealand health and disability system outlines the central role the Ministry has in setting a vision, goals and accountabilities for the sector, and in working directly with communities, advocates and health practitioners to determine these.

297. It is within this context that the Ministry must be future-focused, and continually look for opportunities to improve, promote and protect the health of all New Zealanders. At the same time the Ministry continues to work to better understand why health inequity exists for Māori, Pacific peoples and people living in lower socioeconomic areas, and how it can improve its systems and services to meet individual and community needs.

Signed: _____
John Hazeldine

Date: 9 February 2018