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|  | All District Health Boards |
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| **PUBLIC HEALTH SERVICES****TIER LEVEL ONE****SERVICE SPECIFICATION** |
| **STATUS:**It is compulsory to use this nationwide service specification when purchasing this service. | MANDATORY 🗹 |
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Note: Contact the Service Specification Programme Manager, National Health Board Business Unit, Ministry of Health to discuss the process and guidance available in developing new or updating and revising existing service specifications. Web site address of the Nationwide Service Framework Library: http://www.nsfl.health.govt.nz/.

Public Health Services

**TIER LEVEL ONE**

**SERVICE SPECIFICATION**

The tier one service specification for Public Health Services defines the overarching framework and generic requirements for all Public Health Services. This service specification must be used in conjunction with one or more of the tier two service specifications and, where appropriate, tier three specifications (see section 6, Service Components).

Specifications are hierarchical, so that everything in this specification applies to *all* subordinate tier two and tier three specifications for Public Health Services. Where a particular tier two specification has one or more subordinate tier three specifications under it, then that tier two specification applies to all of those tier three specifications.

**1. Background**

Public health is “the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society”[[1]](#footnote-1).

Some Public Health Services are mandated by legislation (see section 8.2) and some by international obligations (section 8.3). Other services are justified on the basis of their efficacy, evidence of health need and good practice.

In a New Zealand context, the principles of the Treaty of Waitangi / Te Tiriti o Waitangi, including partnership, protection and participation, are also relevant to the planning and delivery of Public Health Services.

In providing for the funding and provision of Public Health Services, the New Zealand Public Health and Disability Act 2000 has as its purposes the improvement, promotion and protection of the health of all New Zealanders. Under the Health Act 1956 the Ministry of Health (the Ministry) has a statutory function to improve, promote and protect public health.

The Ministry is accountable to the Minister of Health for discharging the Crown's responsibilities for public health protection and the administration of legislation. The Ministry is therefore responsible for planning, specifying, funding and, in some cases, delivering Public Health Services at a national level. The Ministry’s leadership role is augmented by the functions and statutory independence of the Director of Public Health.

There is solid evidence of major health gains from preventive services that address not only individual behaviour but also the environments in which people live. Because many of the strongest influences on health and wellbeing come from outside the health sector, effective action to sustain and improve public health cannot be solely the responsibility of the health sector[[2]](#footnote-2). This requires coordinated action across different areas of government and addresses a broad range of social, economic and lifestyle issues[[3]](#footnote-3).

Public Health Services are provided either directly by the Ministry, or by the Ministry contracting with a wide range of service providers[[4]](#footnote-4). Service providers will take an integrated approach to service planning and delivery, and work collaboratively with other public health and personal health service providers.

The relationship accord *Kia Tutahi standing together*[[5]](#footnote-5) is recognised as underpinning the multiple relationships between the Ministry and NGO providers.

Priority areas for Public Health Services include addressing non-communicable disease risk factors, improved prevention and control of infectious diseases, mental health promotion, well child promotion, environmental health and improved coordination between health providers and between Public Health Service providers and other sectors.

***Vision and Principles:*** The Ministry’s vision for Public Health Services, being both part of and acting as a catalyst for the organised efforts of society, is to improve, promote and protect the health and independence of New Zealanders by supporting and enabling communities, whānau, and individuals to:

1. live, work, learn and play in healthy and safe environments
2. lead healthier lives in respect of a wide range of matters, including physical activity, nutrition, breastfeeding, tobacco, alcohol and other drugs etc (including policies that create healthy environments and inform and support healthy choices)
3. access to screening programmes which identify those individual who are more likely to be helped than harmed by further tests or treatments to reduce the risk of disease or conditions and associated complications
4. be free of communicable and vaccine-preventable diseases
5. sustain and improve their mental health and wellbeing, to build resilience and attain their full potential
6. reduce the burden of acute and chronic disease and injury
7. enjoy positive interpersonal relationships
8. prepare for and respond to emergencies and disasters with confidence
9. enjoy equitable health outcomes.

Services provided pursuant to this vision are supported by a wide range of national and international research which yields evidence-informed principles and methods to promote health and prevent illness.

***The Ottawa Charter*** for health promotion is one of the defining frameworks for public health action. Health promotion is *“… the process of enabling people to increase control over, and to improve, their health*”[[6]](#footnote-6). The Ottawa Charter identifies five key strategies:

1. building healthy public policy
2. creating supportive environments
3. strengthening community action
4. developing personal skills
5. reorienting health services.

Consistent with the Ottawa Charter, the following principles inform and shape Public Health Service delivery in New Zealand:

1. focusing on the health and wellbeing of populations, communities and whanau, as well as individuals
2. understanding and influencing the determinants of health
3. prioritising improvements in Māori health
4. reducing inequitable health outcomes [[7]](#footnote-7)
5. basing practice on the best available evidence
6. building effective partnerships across the health sector and with other sectors
7. anticipating and remaining responsive to new and emerging health threats.
8. **Service Definition**

Public health is defined as the health and wellbeing of all the people of New Zealand or a community or section of such people[[8]](#footnote-8). Public Health Services are publicly funded services that improve, promote and protect public health at a community or population level, and include services and programmes focused on identifiable sub-populations. Some Public Health Services are available directly to individuals, for example, screening programmes.

Because Public Health Services address the health needs of diverse population groups, to be effective they are usually delivered by way of comprehensive programmes that evolve in response to, and in anticipation of, changing health needs, priorities, evidence and organisational structures. Coordination of service planning and delivery is therefore a dynamic process that occurs at the local, regional and national levels.

Active collaboration by public health providers with primary and secondary health care providers, NGOs, health sector Crown entities and other sectors (including local government, food safety, biosecurity, housing, occupational safety and health, education, environment etc) is also a necessary feature of effective public health practice. For this reason, outputs produced by providers for the purposes of this specification include actual service provision, and also outputs produced to inform or influence other agencies and sectors with a view to improving public health outcomes.

1. **Service Objectives**

**3.1 General**

The purpose of the New Zealand Public Health and Disability Services Act 2000 is “to achieve for all New Zealanders… the improvement, promotion, and protection of their health.” In achieving this outcome, the Act also seeks “…to reduce health disparities by improving the health outcomes of Māori and other population groups”.

As already noted, a focus on proven preventive measures and earlier intervention can result in significant health gains[[9]](#footnote-9) and contribute to efficient service delivery. As community health needs and provider capabilities vary around the country, the Ministry expects Public Health Services to demonstrate:

* national consistency in the standard, quality of services and improvement activities while recognising that flexibility in delivery will often be desirable or necessary at a local level
* services being culturally appropriate and responsive to Māori
* integration in the planning and delivery of services, with a particular focus on “whole of health system” approaches (especially by DHBs). The potential for improved health outcomes from system integration occurs across different sectors and across the continuum of health.

The outcomes sought by Public Health Services are:

* a healthier population
* a reduction of inequity in health outcomes
* improvements in Māori health
* increased safeguards for the public’s health
* a reduced burden of acute and chronic disease.

**3.2 Māori Health**

The public health approach to improving Māori health requires both enhancing health outcomes in general terms and attention to the particular areas where Māori have inequitable health outcomes. Health providers are expected to provide health services that will contribute to realising this aim.

This may be achieved through mechanisms that use appropriate models of health and service delivery and facilitate Māori access to services. Provision of appropriate pathways of care might include, but are not limited to:

* ensuring that the services are, and can demonstrate, cultural competence
* that services are provided that meet the health needs of Māori.

It is expected that, where appropriate, there will be Māori participation in the decision making around, and delivery of, services that affect Māori health outcomes.

**3.3 Reducing inequity in health outcomes**

The World Health Organization defines equity as, “the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically or geographically”.

Both the Ministry and public health providers have an important role in supporting intersectoral approaches to address the social determinants of health and a critical role in ensuring health services themselves do not exacerbate inequitable disparities in health outcomes between population groups. This means that, to be effective, services must ensure they are accessible and relevant to all people and groups.

Inequitable health outcomes are evident amongst populations with different levels of underlying social advantage/ disadvantage. This may be on the basis of socioeconomic status, ethnicity, gender, stage of the life course (children/older people), locality, or due to discrimination or marginalisation (including on the basis of disability, religious affiliation, and sexual orientation or refugee status). These disparities result in cumulative effects throughout life and across generations. The causes of disparities in health outcomes are complex and largely arise from the inequitable distribution of and access to, the wider determinants of health such as income, education, employment, housing and quality health care amongst populations[[10]](#footnote-10).

In New Zealand, the health disparities between Māori and non-Māori are enduring and require direct and ongoing attention. It is expected that planners and service providers will address this issue explicitly. Public health approaches to address health inequities should be aligned with *He Korowai Oranga Māori* *Health Strategy* (Ministry of Health 2002) and include but not be limited to:

* the use of health equity[[11]](#footnote-11) / whanau ora / health impact assessment tools, including engaging relevant stakeholders, to identify the populations experiencing the greatest disadvantage, and develop quality services and engage relevant stakeholders to support coordinated action
* influencing the development and implementation of policies and services across sectors, with the intention of minimising health harm and/or maximising health gain
* monitoring and assessing the health impact of all services, policies and interventions on disadvantaged groups
* ensuring Public Health Services are accessible, acceptable and appropriate in the relevant social, cultural and geographic context
* supporting the participation of communities in the decision making around, and delivery of, services that affect their health outcomes.

Where appropriate, public health providers should involve other health service providers and other sectors in such discussions.

Compared with the total New Zealand population, Pacific peoples also have poorer health status across a variety of measures. These include child and youth health, risk factors leading to poor health and long-term conditions. The Service must be responsive to Pacific health needs and identified concerns, and should be aligned with *Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010–2014*. Ala Mo'ui sets out priority outcomes and actions that will contribute to the Government’s overarching goal that all New Zealanders, including Pacific peoples, achieve better health outcomes.

**4. Service Users**

Within a framework of universal coverage and a focus on promoting wellbeing at a population level, service users are defined by the common characteristics of groups known or perceived to be at risk on the basis of sound epidemiological evidence. Population groups may be differentiated on the basis of locality, ethnicity, age, sex/gender, disability or other shared characteristics. Because risks to public health are inherent in a wide variety of physical and social environments, affecting population groups differently according to context, Public Health Services need to be designed and delivered with consideration for the characteristics of vulnerable groups and the various circumstances in which risks arise.

This means that, to be effective, service providers (for example, in the promotion and/or maintenance of water fluoridation) must engage with affected groups in ways that are accessible and acceptable in the relevant geographic, social and cultural contexts. Programmes are generally designed and evaluated, and may be delivered, with significant participation from affected groups.

This diversity is especially relevant to improving Māori health and addressing inequitable health outcomes between population groups.

**5. Access**

**5.1 General**

Public Health Services must be universally available, accessible, acceptable and of a consistently high quality for the whole population.

Public Health Services are generally provided free of charge to those eligible and are designed to overcome physical, cultural, language and other barriers to access, within the context of resource constraints, population distribution and geographic variables.

**5.2 Prioritisation**

Public Health Services are prioritised for population groups based on evidence that:

1. there is a significant impact on the current and future health status of the total population or priority groups in terms of morbidity, mortality, quality of life, and/or potential years of life lost
2. there are effective population-based methods, to improve, promote or protect health or safety, or prevent disease, in respect of the particular issues; or there are innovative methods that could be evaluated
3. addressing the issue will contribute to promoting health status among priority communities such as Māori, Pacific and disabled people
4. addressing the issue will provide the best health gain in terms of the required resources
5. there is public support for addressing the issue[[12]](#footnote-12)
6. programmes developed to address the issue are sustainable over time and across sectors (or a short-term intervention will give a sustainable benefit)
7. other sectors of government and the community are engaged in efforts to address the issue, and benefits for all can be gained by shared or complementary work
8. the issue is not currently being addressed, or is only being partially addressed, by any other agency or organisation ie, there is a gap.

Public Health Service providers should coordinate to plan and deliver integrated services, taking account of local, regional and national priorities.

**5.3 Eligibility**

The criteria for eligibility for publicly funded health and disability services are set out in the Health and Disability Services Eligibility Direction 2011, Gazette notice 6367. This is a Ministerial direction under section 32 of the New Zealand Public Health and Disability Act 2000. Refer to the Ministry’s website: http://www.moh.govt.nz/eligibility for detailed information on eligibility.

Being eligible gives a person a right to be considered for publicly funded health or disability services (ie, free or subsidised). It is not an entitlement to receive any particular service. Notwithstanding this, acute public health risks should be investigated and managed on clinical and epidemiological grounds, irrespective of the nationality or residency status of the persons concerned. For further information see also Appendix One.

**5.4 Exclusions**

Food issues (including commercial and non-commercial food safety, quality, labelling, composition, packaging, containers, transportation, importation, etc) are the responsibility of the Ministry for Primary Industries and are not (except for the interface with surveillance and the investigation of disease outbreaks and illness) covered by this specification.

Similarly, health and safety in workplaces is the responsibility of employers, employees and the Ministry for Business, Innovation and Employment[[13]](#footnote-13).

Local government also performs a range of functions, both statutory and discretionary, that contribute significantly to public health outcomes. However, other than the statutory relationships between designated officers and territorial authorities and any services specifically funded by the Ministry, the wider public health role of local government is outside the scope of this service specification.

In circumstances where the respective public health roles and responsibilities of another provider or agency are not clear, or where it proves difficult to engage with another provider or agency, the service provider must discuss this with the Ministry.

It is important to note the scope for confusion between publicly funded health services and public health services - the latter are a subset of publicly funded health services, but do not generally include diagnostic and personal treatment services such as GP consultations, outpatient and inpatient services, disability support services etc.

There may, however, be an overlap eg:

* when a patient is seen by their GP or hospital and diagnosed with a notifiable disease, there may then be a need for the public health service to trace contacts of the case, to help prevent further spread
* when a clinician refers a patient to a Public Health Service for advice and support to reduce risks such as smoking cessation or obesity (eg, Green Prescription).

**6. Service Components**

The Public Health Service components comprise five core public health functions, as summarised in the table below[[14]](#footnote-14). Each service component corresponds to a tier two service specification[[15]](#footnote-15).

The Ministry recognises the advantages of combining functions, settings and issues-based approaches for the integrated provision of comprehensive Public Health Services.

Table 1: Tier two service specifications based on core public health functions

| **Service Components*****(ie, tier two service specifications)*** | **Description** |
| --- | --- |
| 1. Health assessment and surveillance | Understanding health status, health determinants and disease distribution to inform action |
| 2. Public health capacity development | Ensuring services are high quality, effective, efficient and sustainable |
| 3. Health promotion | Enabling people to increase control over and improve their health |
| 4. Health protection | Protecting communities against public health hazards |
| 5. Preventive interventions | Population programmes delivered to individuals |

Functional service components will form the basis for service purchasing, planning and delivery. However, public health functions are rarely performed in isolation and effective Public Health Services generally combine a range of complementary functions and associated activities. Please refer to the corresponding tier two (and where appropriate, tier three) service specifications for full details relevant to each specific Public Health Service component.

In providing one or more of the service components, and noting that reporting and contractual obligations may also be linked to these components, providers may configure their services in ways that reflect their own planning, organisational and service delivery requirements, so long as they meet the public health needs of their service users / communities, given the available resources.

With a view to the development of effective and efficient services, providers may choose to configure their outputs in line with the following service areas, if this assists them with planning and delivery:

1. Environmental and border health
2. Communicable disease prevention and control
3. Social Environments and Health Promoting Schools (including health impact assessment)
4. Well Child / Tamariki Ora Promotion
5. National screening programmes
6. Prevention of alcohol and drug-related harm
7. Tobacco control
8. Healthy physical activity and nutrition
9. Sexual and reproductive health promotion
10. Mental health promotion
11. Injury prevention
12. Preventing and minimising gambling harm
13. Public health infrastructure services

Providers of public health services must meet all relevant statutory responsibilities.

**7. Service Linkages**

There are linkages between this Service Specification and other tier one service specifications, for example Smoking Cessation. There are also linkages between this service specification and other services, providers and sectors. Such linkages include, but are not limited to, the following:

| **Sector** | **Nature of linkage(s)** | **Public Health Provider Accountabilities** |
| --- | --- | --- |
| Health care providers | 1. Planning, funding and service delivery
2. Formal agreements (eg contract, Memorandum of Understanding (MoU), alliance agreements between health service providers to achieve shared outcomes
3. Communication, coordination and collaboration on an *ad hoc* basis
 | 1. Effective communication and support in achieving shared objectives
2. In conjunction with DHB planning and funding teams, improve the planning, funding and implementation of public health programmes, especially to promote collaboration, consistent messages and reduce service gaps and duplication
3. Inform the planning (including DHB regional plans), funding and implementation of all DHB services and programmes (not just public health programmes) to reduce health inequities
4. Develop DHB-endorsed position statements on priority public health issues
5. Promote public health action in personal health settings (eg, early interventions)
6. Promote a coherent continuum of services between determinants of health, primary prevention and personal health care, particularly through information management and 24/7 accessibility of services, such as helplines and e-therapy, where appropriate
7. Include iwi or other appropriate Māori representation on governance bodies
 |
| Neighbouring public health units | Mutual interest in regional coordination | Develop regional approaches to Public Health Service planning and delivery  |
| Health Promotion Agency | Parallel responsibilities for:1. promoting health and wellbeing and encouraging healthy lifestyles
2. preventing disease, illness and injury
3. enabling environments that support health and wellbeing and healthy lifestyles
4. reducing personal, social and economic harm, including advice and research on alcohol-related issues
 | 1. Effective coordination and collaboration in achieving shared public health outcomes
2. Improve the planning, coordination and delivery of public health programmes (especially health promotion) to promote collaboration, consistent messages, and to reduce service gaps and duplication
3. Contribute as required to fulfil government requirements for a whole of government response to public health issues
 |
| Local government (including regional councils where appropriate) | Parallel responsibilities for or interests in:1. environmental health, including air and water quality
2. built environment
3. resource management
4. emergency management
5. community safety
6. water safety
7. transport
 | 1. Situational preparedness for emergencies and untoward events, including surveillance, risk assessment and surge capacity
2. Oversight role of the Medical Officer of Health in relation to a number of the environmental health functions of territorial authorities under the Health Act 1956, including drinking water (refer 8.2)
3. Active participation of public health services in the public processes for planning and resource consents under the Resource Management Act 1991 and the Local Government Act 2002
4. Engaging with councils to help inform their assessments of water and other sanitary services as required under s.125 of the Local Government Act 2002
5. Engaging with councils to promote water fluoridation as a safe, effective mechanism to reduce the burden of dental decay
6. Planning for public health emergencies is coordinated with local government roles under the Civil Defence Emergency Management Act 2002 as provided for in the National Health Emergency Plan
7. Public health service activities in relation to the built environment are coordinated with territorial authority functions under the Building Act 2004
8. Promoting use of Health Impact Assessment for policy and programme development
9. Promotion of sustainable, resilient socially inclusive and healthy communities through good urban design
10. Contributing to Local Alcohol Policies and collaborating with Police and Liquor Licensing authorities to reduce harm associated with alcohol
11. Providing public health input to Regional Transport Committees and their strategic planning and road programme development (refer Land Transport Management Act 2003)
 |
| Food Safety (Ministry for Primary Industries) | 1. Interface with any food issues, including food safety, food composition, food premises and food sources (commercial and non-commercial) identified through communicable disease surveillance and outbreak investigation, and other surveillance activity in the community
2. Management of food borne illness in the community
 | 1. Monitoring, surveillance and information sharing
2. Incident and emergency response
3. Liaison re food withdrawals and recalls.
 |
| Hazardous substances and the Environmental Protection Authority | Responsibilities under section 98 of the Hazardous Substances and New Organisms (HSNO) Act 1996 for enforcement in specified locations or circumstances | Where public health may be at risk, Public Health Unit HSNO enforcement officers may (depending on the circumstances):1. provide information and advice to another agency or the public
2. provide active support, or
3. where appropriate, take action to protect public health
 |
| Iwi, hapu and other Māori agencies | 1. Coordination in achieving public health outcomes
2. Formal agreements (eg contract, MoU) between health service providers to achieve shared outcomes
3. Informal coordination and collaboration on an *ad hoc* basis
 | 1. Improve the planning, coordination and delivery of public health programmes (especially health promotion) to promote collaboration and assist services to improve Māori health and reduce inequitable health outcomes
2. Promote understanding of Māori models of health and Ministry strategies (eg*, He Korowai Oranga*) to address Māori health needs
3. Engage with local (mana whenua) Māori during decision making, programme design and implementation, to ensure that planning, coordination and delivery of public health programmes is specific and appropriate to whānau, hapu and iwi within the service areas
4. Promote application of the Whānau Ora planning tool to address Māori health needs
 |
| Non-Government Organisations (NGOs), including bodies representing ethnic minorities | 1. Coordination in achieving public health outcomes and contributing to social cohesion
2. The relationship accord *Kia Tutahi standing together*
 | 1. Effective communication and support in achieving shared objectives
2. Improving the planning, coordination and delivery of public health programmes (especially health promotion) to promote collaboration, consistent messages, reduction of service gaps and duplication, and reduction of inequalities in health
3. Promoting community engagement in programme design and implementation
 |
| Other government agencies | 1. Coordination as negotiated by MoU, contract or other form of agreement, or on an *ad hoc* basis.
2. The relationship accord *Kia Tutahi standing together*
 | 1. Effective communication and support in achieving shared objectives
2. Improving the planning, coordination and delivery of public health programmes (especially health promotion) to promote collaboration, consistent messages, and to reduce service gaps and duplication
3. Contributing as required to fulfil Government requirements for a whole of government response to designated issues
 |
| Private Sector | 1. Voluntary measures to improve public health outcomes
2. Shared interest in reducing costs of ill health
 | Effective communication and collaboration to achieve shared objectives |
| Universities and research institutions | Common interest in strengthening and disseminating the evidence base for public health | 1. Remain well informed of emerging evidence base and good practice
2. Access services/expertise as appropriate for workforce development purposes
 |

**8.** **Quality Requirements**

**8.1 General**

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

**8.2 Public Health Legislation**

Generic requirements and specific reporting requirements for providers of regulatory Public Health Services are specified in the tier two specification for Health Protection.

Acts administered by the Ministry (including regulations made under these Acts as appropriate) for which the Ministry has policy and primary implementation responsibility are listed in Appendix Two.

Acts administered by other departments but for which providers of public health regulatory services may have certain implementation and /or enforcement responsibilities are also listed in Appendix Two.

**8.3 International Obligations**

New Zealand is subject to a variety of international agreements that are relevant to public health, for example, the United Nations Convention on the Rights of the Child, the International Code of Marketing of Breast-Milk Substitutes and article 12 of the International Covenant on Economic, Social and Cultural Rights[[16]](#footnote-16) (as interpreted by the United Nations Economic and Social Council in its General Comment No. 14, which defines the essential elements of the right to health, depending on conditions prevailing in a particular State, such as the availability, accessibility, acceptability and quality of services[[17]](#footnote-17)).

For the purposes of this specification, the two principal international agreements are:

***8.3.1 International Health Regulations (IHR) 2005***

The IHR 2005 is a treaty adopted by the World Health Assembly in May 2005. This treaty informs the implementation of a range of public health functions, and key provisions are reflected in New Zealand law. The IHR 2005, which entered into force in June 2007, take an all-risks approach to the management of global threats to public health, although in practice, the primary focus remains on communicable disease.

Under the IHR 2005, New Zealand must:

1. develop and maintain the capacities to detect, investigate, manage and report all potentially serious disease related events. These capacities must be in place locally/regionally, nationally and at the border
2. establish a National IHR Focal Point (NFP) to provide a single point of contact between NZ and WHO. The NFP performs a whole-of-health-sector, whole of government information collation and dissemination function. The NFP role is performed by the Office of the Director of Public Health in the Ministry of Health
3. through the Ministry, receive and rapidly assess the significance of, reports of potentially serious public health events to determine whether or not they must be urgently reported to WHO by the NFP. This includes the use of the Decision Instrument as provided for in Annex 2 of the IHR 2005
4. within 72 hours of receipt of information by the Ministry, the NFP must notify WHO of events involving even only a single case of smallpox, poliomyelitis, SARS and human influenza caused by a new subtype
5. within 48 hours of receipt of information by the Ministry of *any* event involving cholera, pneumonic plague, yellow fever, viral haemorrhagic fevers, west nile fever or *any* unusual or potentially serious public health event, the Ministry must assess the event using the Decision Instrument, and, where notification is required, notify WHO within a further 24 hours.

Designated Officers and Public Health Units play a vital role in ensuring that the above obligations are met, and in particular must maintain close communication with the Ministry to ensure that the requirements under (i), (iv) and (v) above are able to be discharged in a timely manner. Public Health Units are the 'competent authorities' for the purposes of the IHR 2005.

***8.3.2 Framework Convention on Tobacco Control***

The Framework Convention on Tobacco Control is a treaty under the auspices of WHO to which some 160 countries are a party. The text was adopted by the World Health Assembly in May 2003 and it entered into force on 28 February 2005. New Zealand ratified the treaty in January 2005. The Convention governs the advertising, pricing, taxation, packaging and labeling of tobacco products.

**8.4 Guidance Material**

Providers of Public Health Services are encouraged to refer to:

* *The New Zealand Health Strategy,* Minister of Health, December 2000 (mandated under the NZPH&D Act 2000)
* *Achieving Health for All People,* Ministry of Health 2003
* *Te Uru Kahikatea The Public Health Workforce Development Plan 2007 – 2016,* Ministry of Health, 2007
* *The Social, Cultural and Economic Determinants of Health in New Zealand: Action to Improve Health,* National Health Committee, 1998
* *Re-thinking urban environments and health,* Public Health Advisory Committee, 2008
* *A Health Equity Assessment Tool (Equity Lens) for Tackling Inequalities in Health,* Ministry of Health, 2004
* *A Guide to Health Impact Assessment: A Policy tool for New Zealand,* Public Health Advisory Committee, 2005.

Providers may also wish to refer to *Core Public Health Functions,* a report of the New Zealand Public Health Clinical Network, issued 30 September 2011[[18]](#footnote-18).

**8.5** **Political Neutrality**

Parties to Public Health Service contracts acknowledge that they must comply with the conventions relating to the political neutrality of the state service, and agree that they will deliver the agreed services in a manner that is consistent with, and maintains, their and the Ministry’s actual and perceived political neutrality. Please refer to the *Standards of Integrity and Conduct*, issued by the State Services Commissioner[[19]](#footnote-19).

Where a provider which is part of the wider state sector (eg, a Crown entity such as a DHB) makes a submission to a parliamentary select committee on a matter within the scope of this specification, the provider should secure their own organisation's approval at the appropriate level eg, CEO, board or equivalent, and, give advance warning of their submission to the office of the Minister of Health.

The Ministry acknowledges that a provider’s obligation to perform the agreed services does not limit its ability to carry out any other activities. However, the provider must ensure that its other activities outside the services contracted for are clearly separate from, independent of, and not in conflict with, the contracted services.

**9. Purchase Units and Reporting Requirements**

The Public Health Service Purchase Unit Codes are part of a classification system used to measure, quantify, value and monitor the delivery of a service. These codes are found in the joint DHB Ministry Nationwide Service Framework Purchase Unit Data Dictionary on <http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/463>. They are reviewed, agreed and updated annually.

Purchase Units for Public Health Services are included in the tier two and tier three service specifications.

**9.1 Reporting Requirements**

Specific reporting requirements apply at tier two and their associated tier three service specifications as appropriate.

**9.2 Service Specific Requirements**

Public Health Services reporting requirements are as per individual contracts with providers. Service providers must comply with the requirements of national data collections where they are available.

In addition to the information and reporting requirements identified in specifications for Public Health Services, service providers must use their best endeavours to comply with any reasonable request for information from the Ministry.

**Appendix One: Eligibility for publicly funded health and disability services**

Individuals need to meet certain clinical and other assessment criteria to receive many services.

Eligible people include the following:

1. New Zealand citizens and residents (sections B2 and B3 of the Direction)
2. Holders of work visas valid for two years or more (section B5)
3. Australian citizens and permanent residents who have been or intend to stay in New Zealand for at least two consecutive years (sections B6 and B7)
4. Refugee applicants (section B10)
5. Protected persons (section B11)
6. Victims of people trafficking offences (section B12)
7. Certain students, for example those on Commonwealth Scholarships (sections B13, B14 and B15)
8. The dependents of eligible people who are under 18 (section B16).

All children are eligible for Well Child services and for vaccinations listed on the Immunisation Schedule.

Publicly funded services are also offered to otherwise ineligible people in the following situations:

1. partners of New Zealand Aid Programme students (section B20)
2. pregnant women who require maternity-related services if either their partner is eligible or the unborn child (when it is born) will be a New Zealand citizen (section B21)
3. pregnant women who require services to prevent transmission of HIV to their unborn child (section B22)
4. any person suspected of having a scheduled infectious disease or quarantinable disease (as defined under the Health Act 1956), and who may be infectious and so pose a risk to others, is eligible for the following publicly funded services (section B23):
* public health surveillance
* diagnostic and other tests relevant to the disease
* inpatient or outpatient care for the disease, including medications, so as to effectively deal with the risk of the disease spreading
* other follow up, such as contact tracing or counselling, where this is relevant to the management of the risk of the disease spreading.

If there is doubt about whether these provisions apply in a particular case, it should be determined on the judgment of the Medical Officer of Health.

1. if they are receiving, or eligible to receive, compulsory services under the following legislation (sections B23 and B25):
* Tuberculosis Act 1948, or
* Health Act 1956, or
* Alcoholism and Drug Addiction Act 1966, or
* Criminal Procedure (Mentally Impaired Persons) Act 2003, or
* Mental Health (Compulsory Assessment and Treatment) Act 1992, or
* Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
* any Regulations made under any of these Acts.

**Appendix Two: Legislation administered and / or implemented by the health sector**

Acts administered by the Ministry of Health (including regulations made under these Acts as appropriate) for which the Ministry has policy and primary implementation responsibility are as follows:

1. Burial and Cremation Act 1964
2. Epidemic Preparedness Act 2006
3. Health Act 1956 (*note the Public Health Bill, if enacted in its current form, will replace most of the Health Act*)
4. Misuse of Drugs Act 1975
5. Psychoactive Substances Act 2013
6. Radiation Protection Act 1965
7. Smoke-free Environments Act 1990
8. Tuberculosis Act 1948 (*note the Public Health Bill, if enacted in its current form, will repeal the Tuberculosis Act*).

Acts administered by other departments but for which providers of public health regulatory services may have certain implementation and /or enforcement responsibilities include:

1. Biosecurity Act 1993
2. Building Act 2004
3. Civil Defence Emergency Management Act 2002
4. Education (Early Childhood Services) Regulations 2008
5. Hazardous Substances and New Organisms Act 1996
6. Local Government Act 2002
7. Prostitution Reform Act 2003
8. Sale and Supply of Alcohol Act 2012
9. Waste Minimisation Act 2008.
1. Acheson D, *Committee of Inquiry into the Future Development of Public Health Function*, HMSO, London 1988. [↑](#footnote-ref-1)
2. *Health is Everybody’s Business*, Public Health Advisory Committee, 2006. [↑](#footnote-ref-2)
3. New Zealand Health Strategy 2000 [↑](#footnote-ref-3)
4. District Health Boards (DHBs), DHB-based public health units, non-governmental organisations (NGOs), Māori health providers, Crown entities, primary health care providers and local government. [↑](#footnote-ref-4)
5. *Kia Tutahi standing together:* The relationship accord between the communities of Aotearoa New Zealand and the Government of New Zealand. [↑](#footnote-ref-5)
6. *Ottawa Charter*, World Health Organisation, 1986 [↑](#footnote-ref-6)
7. Health service utilisation and health outcomes vary between population groups for many reasons. Where population groups experience disproportionately worse (or better) health outcomes as a result of structural, systematic or otherwise unfair exposure to the factors that promote or reduce their chances of good health, such inequitable disparities should be addressed through the organised efforts of society, either directly by public health services, or by such services acting as an agent for positive change in their interactions with other providers and sectors by improving the health of specific population groups and the population overall. See also section 3.3 [↑](#footnote-ref-7)
8. Adapted from the NZ Public Health & Disability Act 2000 [↑](#footnote-ref-8)
9. Statement of Intent: 2012/13 to 2014/15 Ministry of Health, May 2012 [↑](#footnote-ref-9)
10. *A Guide to Health Impact Assessment: A Policy tool for New Zealand,* Public Health Advisory Committee 2005. [↑](#footnote-ref-10)
11. *A Health Equity Assessment Tool (Equity Lens) for Tackling Inequalities in Health,* Ministry of Health, May 2004 [↑](#footnote-ref-11)
12. This criterion recognises that sometimes the degree of public support is a consideration. For example: (a) where all other factors are equal, then it may appropriate to prioritise services for which there is community support or (b) if all other factors are nearly equal, but there is overwhelming public support for one option, then it may get precedence. This is about acknowledging the importance of community support, being receptive to legitimate community expectations and recognising that community support for a service can increase its effectiveness and efficiency. [↑](#footnote-ref-12)
13. NB as at November 2013, The government plans to establish a new standalone workplace health and safety regulatory agency called **WorkSafe New Zealand**. This new agency is scheduled to become operational in December 2013. [↑](#footnote-ref-13)
14. The core functions approach was developed by the Public Health Clinical Network, based on models developed by WHO and other international sources, see also section 8.4 [↑](#footnote-ref-14)
15. For an interim period, this tier one Specification is likely to apply to the 13, service-based, tier two specifications promulgated circa 2010 and 2011. Revised, functions-based, tier two specifications are expected to be in place for 2015/16. [↑](#footnote-ref-15)
16. UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, available at: http://www.unhcr.org/refworld/docid/3ae6b36c0.html [accessed 4 February 2013] [↑](#footnote-ref-16)
17. United Nations Economic and Social Council *Substantive issues arising in the implementation of the International Covenant on economic, Social and Cultural rights: General Comment No. 14* (2000) E/C.12/2000/4 [↑](#footnote-ref-17)
18. Please note this is not a Ministry document, but is available on: http://www.populationhealth.org.nz/publications.aspx [↑](#footnote-ref-18)
19. Code issued under the State Sector Act 1988, available on the SSC website. [↑](#footnote-ref-19)