# A review of the role and responsibilities of national ministries of health in five countries

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## Summary

This report reviews the role and responsibilities of ministries of health in five countries: Denmark, France, Germany, New Zealand and Spain. Ministries play an essential role in governing health systems. They are vital in shaping and maintaining the regulatory framework within which health services are funded and delivered. These frameworks, often in the form of national legislation, also define the roles of other health system actors and their responsibility vis-à-vis the Ministry of Health. In addition, ministries are instrumental in developing and implementing government policies and in ensuring that health services are accessible, equitable and affordable.

Ministries vary substantially in size, structure and remit, size of internal departments and the policy areas they oversee. This variation largely reflects differences in mandate but also in the wider political and health system context. The countries selected for this report represent a variety of political systems: traditional federalist (Germany) and quasi-federalist systems (Spain), systems with a high degree of regional responsibility for public services (Denmark) and more centralised countries (France, New Zealand) with contrasting government systems. Federalist and decentralised countries devolve substantial powers to regional and/or local governments, while centralist countries have tended to retain control at the centre. Countries also vary widely with regard to the funding and organisation of health care.

This review has been informed by several key sources: (a) a review of the literature on the role of the ministry of health in health system governance in the countries in question; (b) information provided by country informants in response to a detailed questionnaire; and (c) websites of governments and other organisations identified through (a) and (b). The responses submitted by country informants provided a wealth of information on the organisational structure of ministries, their key responsibilities, mechanisms of accountability, the legislative framework in which they operate and their role in relation to other governmental bodies, arm's length agencies, regional governments and professional and provider organisations. Country informants also provided case studies illustrating ministries' scope of action in cases of health system failure.

The review mainly focuses on the role of ministries of health at the level of central government. It comprises five country case studies and an introduction highlighting some key differences between ministries of health in these countries. The report touches on several topics that are potentially relevant for an understanding of the role and functioning of ministries of health. Topics that may warrant further exploration include: the dynamics within government and, in particular, the relationship between the Ministry of Health and other ministries, such as the Ministry of Finance; the influence of the prime minister, president or equivalent on ministries' activities; the distribution of power within the ministry and the role of different departments; the changing and possibly increasing role of political advisors; the relationship between

civil servants and ministry staff with other professional backgrounds; lines and forms of accountability between the ministry, its agencies and regional bodies; and the public perception of a ministry's responsibilities in relation to its actual ability to exercise this responsibility.

Given the limitations of the largely descriptive data available at short notice, this report does not attempt to draw conclusions as to whether some ministries are better able to fulfil their role or better equipped to meet their objectives. Indeed, it is a challenging task simply to describe the allocation of roles and responsibilities of ministries of health, since frequently there are important if subtle differences between formal definitions and what happens in practice.

## *Features of Ministries of Health*

Ministries vary substantially in size, organisational structure and remit. In Germany, France and New Zealand, ministries are stand-alone government bodies while in Denmark and Spain, the government section responsible for health forms part of a ministry with a broader remit. In Germany responsibility for health was transferred from the previous Ministry of Health and Social Security to the now separate Ministry of Health following the federal election in 2005. The 2007 presidential election in France also resulted in a redistribution of responsibility for health system governance. The social affairs portfolio has been given to a separate ministry and a new Ministry of National Finances, Public Accounts and Civil Services is now responsible for all public spending, including spending on health. In Denmark the Ministry of the Interior and Health oversees the governance of health care exercised through regions and municipalities but is also involved in other aspects of regions' and municipalities' activities. The Ministry of Health at central level in Spain is responsible for health as well as for consumer affairs.

Ministries differ substantially in structure and internal organisation. This largely reflects differences in mandate and responsibilities but may also be related to differences in organisational culture and administrative traditions. Ministries' mandates are shaped by the political system. In countries where regional governments have the main responsibility for organising (and providing) health care, the role of the national ministry of health may be limited to providing the general regulatory framework. In Germany, for example, hospital care is the responsibility of the *Länder* (states); consequently, the federal Ministry of Health's scope of intervention in the hospital sector is limited to selected areas only. Regional governments in Spain appear to be in a similarly strong position vis-à-vis the central Ministry of Health as many functions relating to health system governance have been devolved to the regions. In Germany, the scope of intervention of the federal Ministry of Health is further limited by the strong role of corporatist actors in the health sector. Key functions such as defining the publicly-financed benefits package and price-setting for goods and services are typically carried out by associations of sickness funds and provider associations at central and/or regional level.

Staff numbers also vary among ministries, ranging from 270 at the Danish Ministry of the Interior and Health (of whom only one third work in the health sector) to 1,100 at the Ministry of Health and Consumer Affairs in Spain. However, given the variation in the scope of different ministries' activities and the range of functions discharged by other agencies, it is difficult to draw meaningful conclusions based on the number of staff in a given ministry.

One of the key tasks of any ministry is to provide support to the minister who, in all five countries, is a member of the elected government. Thus, all ministries reviewed here are directly accountable to parliament and, through the minister of health, are answerable to the prime minister (or equivalent) and his/her cabinet. Formal accountability requirements frequently involve reports to parliament on ministry activity and on the performance of the health system. However, approaches and indicators of performance vary widely, as do requirements to make information publicly available. Only in New Zealand is the performance of the Ministry of Health annually measured by parliament against previously stated objectives.

A core function of all ministries of health is to develop the regulatory framework to ensure the functioning of the health system. This typically involves the preparation of health policy legislation to be passed by parliament. In addition, ministries normally issue directives, executive orders and guidelines within the scope of responsibilities assigned to them; these are normally binding for all actors in the health system.

## *Role of the Ministry of Health in relation to collecting funds, budget setting and resource allocation*

In *Denmark* central and local taxes constitute the main mechanism for financing health care. The size of the national budget for health is determined collectively through annual negotiations between the Ministry of Finance, the Ministry of Health, the National Association of Local Authorities and 'Danish Regions' (the representative body of the 98 municipalities and the five regions respectively). The negotiations establish the level of central government subsidies to the regions and municipalities. They also establish the level of redistribution between municipalities to adjust for differences in local tax revenues and the size of one-off or ongoing grants for specific nationally-determined programmes and initiatives. They further set a ceiling on regional and municipal spending on health. The ceiling is not legally binding and municipalities typically respond to budget overspending by raising the level of local taxes.

The outcome of the annual negotiations feeds into the process of determining the central government budget. The Ministry of Finance leads this process. Every year it determines the level of national taxation, which is established by law through the passing of the Finance Act by parliament.[1] It also determines the level of municipal taxes through annual negotiation with the National Association of Local Authorities. Prior to the 2007 administrative reforms, which replaced 14 counties with the five regions, health care was also financed through taxes raised at county level. In contrast, the new regions have no tax-raising powers.

In *France*, management and administration of health care financing largely rests with social security agencies and the health insurance funds. Compulsory contributions are paid by employers and employees and levied on earnings and, since 1991, income. Contribution rates are determined centrally by the government; the actual contributions are collected by local social security offices and pooled nationally.

The role of the central government in health care financing was strengthened following the 1996 Juppé reforms, introducing in 1998 a parliamentary vote to determine an annual maximum ceiling for public spending on health (*L'Objectif nationale de dépenses d'assurance maladie,* ONDAM). Parliament decision is informed by reports prepared by the General Accounting Office, the National Health Conference and by the advice of the Ministry of Health. ONDAM determines a

projected budget for health insurance fund expenditure for the following year. If the projected budget is exceeded, a special 'alert' committee, formed in 2004, can ask the national social security agency to present a financial rescue plan. The ceiling also establishes spending limits for specific health sectors (hospital care, ambulatory care and long-term care). Once these spending limits have been set, the Ministry of Health is responsible for allocating funds to each sector and, for hospitals, to each region.[2] In 2000 a new system required the health insurance funds to sign an agreement with the Ministry of Health specifying a target budget (*Objectif de dépenses déléguées)* for the reimbursement of self-employed health professionals. However, in 2001 the Ministry and the funds were not able to reach an agreement and the target budget has since been abolished.[2]

Yet, while central government control over the national health budget has generally increased during the last ten years, the role of the Ministry of Health in administering the health system has been narrowed as responsibility for health care expenditure has been transferred to a new Ministry of National Finances, Public Accounts and Civil Service after the 2007 presidential elections.

In *Germany*, sickness funds play the most important role in the management of health care financing. Contributions paid by employers and employees are levied on earnings and are compulsory for employees earning less than a specified threshold. At present, each sickness fund (currently around 250) sets its own contribution rate and collects the contributions. If expenditures exceed revenues in a given year, sickness funds are required by law to raise their contribution rate. Sickness funds may not incur deficits; they are fully financial liable. However, if a fund runs into severe financial problems, threatening its sustainability, it is to be supported financially by its respective association.[3] The sickness funds determine budgets for ambulatory and hospital care in co-operation with the Association of Statutory Health Insurance Physicians (ambulatory care) and the German Hospital Association (hospital care).

Traditionally, the Federal Ministry of Health's role in health care financing has been limited to contribute to developing the overall regulatory framework as part of central government. Its role in health care financing is however likely to increase as it will be responsible for determining a nationally-uniform contribution rate from 2009. This will be based on the analysis of an expert panel to be established by the Federal Insurance Office. The Ministry's decision will take direct effect and will not require approval from the Federal Council, although the government will have to inform parliament. A new national health fund will be established to pool all contributions and to allocate resources in relation to population needs back to the sickness funds. Contributions will continue to be collected by individual sickness funds. The Ministry's influence over health care financing may also increase as the level of tax subsidies paid to the sickness funds rises as a consequence of an earlier reform in 2006.

*New Zealand's* central government determines the annual budget for publicly-financed health care in the same way as other public services through a process of negotiation involving the Ministry of Health and the Treasury and their respective ministers. The annual budget is approved by parliament. The central government also sets the employer and employee levies that determine the budget of the Accident Compensation Corporation (ACC). The Ministry of Health allocates the government health budget to 21 District Health Boards (DHBs). Within their allocated budget, DHBs fund specific services for their populations, except for services that are purchased by the Ministry of Health (for example, highly specialised services). DHBs have limited discretion in allocating resources as most of their funds are committed in

advance to implementing national strategies, ministerial priorities and requirements set out in the Operational Policy Framework.

Health care in *Spain* is mainly financed through taxes raised at central and regional level. In 2001 the central government devolved further tax-raising powers to the regions and the role of the regions in financing health care has subsequently increased.[4] Central government allocations to the regions for health form part of a broader process of allocation that aims to compensate for differences in tax revenues and needs. Allocations for health and non-health spending are negotiated annually by the central ministry of health, ministry of finance and regional governments. Regional governments are free to allocate the funds they receive from the central government as they wish, so long as they spend a legally-stipulated minimum amount on health care. Regional ministries of health or their equivalent typically define the overall budget for publicly-financed health care in collaboration with regional ministries of finance and allocate funds by sector.

## *Role of the Ministry of Health in defining the benefits package*

The benefits package has been defined as "the totality of services, activities and goods covered by publicly funded statutory or mandatory insurance schemes or covered and/or provided by national health services" (p. 5).[5] Busse et al (2005) distinguish higher level decisions, referring to a general framework, frequently defined by legislation, that establishes broad entitlements and lower level decisions, specifying entitlements for specific patient groups and selected applications (e.g. specific technologies and procedures). Lower level specifications that shape the availability and/or reimbursement of services frequently emerge from a combination of legislation passed by parliament, and other legal instruments such as decrees, orders or directives issued by central or regional governments, subordinate agencies or corporatist bodies and other documents and guidelines considered as binding.

In *Denmark* the benefits package is not explicitly defined beyond a broad definition of patient entitlements. In principle, no service is excluded from public reimbursement provided it is clinically indicated: thus treatment decisions are left to the judgement of health professionals.[6] However, legislation does define selected exclusions and inclusions as well as eligibility criteria and co-payments for specific services. The Ministry of Health has little direct influence on the definition of the benefits package, yet many of its decisions and those of its agencies, notably the National Board of Health and the Danish Medicines Agency, affect patients' access to services for example through policies aiming to control supply and demand (such as general practitioner gatekeeping).

Similarly, in *New Zealand*, the definition of the benefits packages is not explicit. It emerges instead in a complex way from frameworks set by the Ministry of Health through national strategies, an operational policy framework for Districts and policies aimed at specific services and patient groups. The Ministry also maintains so-called 'tool-kits' that describe the features of a 'good' service in major service areas. Within these frameworks, most decisions impacting on the availability of services are made at the regional level by the 21 District Health Boards (DHBs) who act as purchasers of services for their populations. The Ministry's reluctance to define benefits explicitly partly reflects previous experience with unsuccessful attempts to define a minimum benefits package in the 1990s. In particular, attempts by the then Core Services Committee to exclude services from public reimbursement proved to be politically infeasible and were subsequently abandoned.[7] However, in the pharmaceutical

sector the Ministry has a more direct influence on availability through its Pharmaceutical Management Agency, (Pharmac). Pharmac determines the eligibility of pharmaceuticals for public subsidy. It has been a stand-alone agency since 2000. Although Pharmac is directly accountable to the Ministry, it has substantial independence in determining the range of drugs that are publicly financed. The Ministry regularly reviews Pharmac's activities but it rarely intervenes directly or vetoes its decisions.

In *Germany*, the federal Ministry of Health's influence over the benefits package is limited, mainly because related responsibility has been delegated to the Federal Joint Committee (G-BA). The Committee is the highest federal level decision-making body in the publicly-financed (i.e. statutory) system. Publicly-financed patient entitlements are broadly defined by the Social Code Book. Entitlements are further specified by the Joint Federal Committee, taking into account the positions of other health system stakeholders, including providers and payers. The Committee's decisions have to be submitted to the Ministry for approval and the Ministry may veto a decision within a period of two months.

In *France* the Ministry of Health is equipped with clearly defined authority to veto the decisions of corporatist actors. Responsibility for defining publicly-financed benefits rests with UNCAM (the national union of health insurance schemes, created in 2004). Its decisions are informed by and must take into account advice from two independent bodies: the High Authority on Health (HAS) and the Union of Voluntary Health Insurance (also created in 2004). Unlike in Germany, the Ministry of Health directly participates in the decision-making process, typically represented by its General Directorate for Health. Although the Ministry has the authority to overrule a decision by UNCAM and to add or withdraw services from the benefits package, in practice it has rarely intervened.

The central Ministry of Health in *Spain* has only limited scope for direct intervention in decisions relating to the benefits package. Patients' entitlement to publicly-financed health care is defined by law in the 2003 Cohesion and Quality Act. The Act specifies general entitlements to health care as defined in the Spanish Constitution that have to be provided by the regions. It also identifies areas in which benefits have to be agreed on by the regions, a process co-ordinated by the Interregional Council of the NHS (CISNS). Formed by representatives of each regional government, the CISNS provides a forum for discussion, negotiation and co-ordination of regional health policies, typically involving several tiers of regional government. CISNS decisions usually have the status of recommendations but may also lead to more formal agreements such as the 2006 Royal Decree 1030/2006 which specifies a number of benefits and includes some additions and exclusions. The Ministry of Health participates in the decision-making process, but its role is as a co-ordinator and broker of regional interests rather than a decision maker.

## *Role of the Ministry of Health in price setting*

Decisions on the price of health goods and services influence overall levels of spending on health, with implications for cost control, sustainability and the wider economy. They also affect labour relations through their effect on professional reimbursement and influence the utilisation of health services in terms of the volume of services that can be provided and any patient co-payments required. As a result, prices are of concern to a wide variety of stakeholders, including professional associations, trade unions, pharmaceutical companies and patient organisations.

*Pharmaceutical pricing in the ambulatory sector*

Pharmaceutical pricing has two main dimensions: determining the price of drugs at different levels of the market chain and determining the level of public reimbursement or subsidy, thereby indirectly determining levels of patient cost sharing. In France and New Zealand, the government exerts some control over the price of pharmaceuticals. In New Zealand, this control is exerted through the Pharmaceutical Management Agency (Pharmac) mentioned earlier. Pharmac is responsible for purchasing pharmaceuticals supplied in the public system and negotiates prices with suppliers. In France, this takes place through negotiation between the pharmaceutical industry and the inter-ministerial Economic Committee for Medical Products (CEPS).

Actors involved in determining reimbursement levels for pharmaceuticals vary across countries. In Spain, this task is performed by an inter-ministerial committee formed by the Ministry of Health and the Ministry of Finance. In France, the reimbursement level is set by the Commission of Transparency (which, as part of the *Haut Autorité de Santé*, is independent of the Ministry of Health). In Denmark and New Zealand, reimbursement levels are determined by government agencies, the Danish Medicines Agency and Pharmac, respectively. Although both agencies are subordinate to and thus directly accountable to the Ministry, the Ministry typically is not directly involved in decision making. However, the Ministry of Health in New Zealand has the authority to overrule Pharmac's decisions (although in practice it has rarely done so). In Germany, publicly-financed generic drugs are subject to reference pricing. Prices for patented drugs are set by the manufacturer and sickness funds are required to reimburse the full price. For generic drugs, levels of public reimbursement and the clustering of drugs to which a reference price applies are determined by the Federal Joint Committee. As noted above, the Ministry of Health has the right to veto its decisions. In all the countries reviewed here, the extent of patient cost sharing for pharmaceuticals is determined at national level, either through legislation, such as the Danish Health Act or the German Social Code Book V, by an inter-ministerial committee (France) or by the Ministry of Health (New Zealand).

*Setting fees for services in ambulatory and hospital care*

In most of the countries reviewed here, the ministry of health is not, or not directly, involved in setting prices for services provided in ambulatory and hospital care. *France* might be an exception as the ministry participates in negotiations on fees for the services of general practitioners and office-based specialists between UNCAM (the national union of health insurance schemes) and the professional unions. Agreements require the Ministry's approval.

In Denmark and New Zealand, while not involved in fee-setting negotiations per se the ministry of health provides benchmark prices for hospital reimbursement. In *Denmark*, most provider fees are determined at the regional level. Fees paid to providers of ambulatory care are negotiated between Danish Regions and the respective professional association. Hospital budgets are negotiated between Danish Regions and the individual hospital; these account for 80% or hospital resources. The remaining 20% of the hospital budget is paid though Diagnosis-Related Groups (DRGs). DRG prices are set by the Ministry of Health.

In *New Zealand*, service fees or hospital prices are locally determined through negotiations between District Health Boards (DHBs) and individual provider organisations (i.e. public hospitals or primary health organisations, PHOs). The Ministry provides benchmark prices for hospital services that are used for payment of

inter-District patient flows and proposes maximum patient co-payments for primary care services. The latter are not statutorily binding for GPs who are self-employed private practitioners.

In *Germany* and *Spain* the national Ministry of Health is not involved in fee setting in the public sector as negotiations are held at regional level only. In Germany, fees for publicly-financed ambulatory services are determined through negotiation between the regional associations of sickness funds and the regional associations of statutory health insurance physicians. Hospital services are paid through DRGs, complemented by a number of specific payments to compensate for costs related to activities such as training, research, emergency care and innovative treatment. Prices per DRG are determined for each region through negotiation between the regional association of sickness funds and the regional association of hospitals.[8]

In the Spanish NHS, providers are mainly funded through budgets and capitation. Services are not individually priced. Budgets for public hospitals and capitation fees for ambulatory care are determined by regional ministries of health, typically in co-operation with public provider organisations.

*Determining salaries of nurses and doctors*

Most national ministries of health tend to not be directly involved in wage determination in the health sector. In France, for example, the salaries of health professionals are typically negotiated between UNCAM (the national union of health insurance schemes) and the unions. However, wage agreements have to be approved by the Ministry. In Denmark and New Zealand salaries are determined through negotiation between professional associations and public payers/employers, usually without participation of the Ministry. In theory, however, the Ministry could intervene if negotiations fail to achieve agreement. Wage negotiations in Germany and Spain mostly take place at the regional level. However, in Spain the Ministry of Public Administration centrally determines a basic salary component for physicians and other health personnel, who enjoy quasi-civil service status.

## *Role of subordinate agencies*

All ministries of health delegate functions to a number of subordinate agencies. These agencies vary substantially in design, structure and size. Subordinate agencies are typically at arm's length from the ministry in the sense that they are separate organisational entities. However, agencies are normally directly accountable to the ministry. Also, the ministry is often held responsible for the performance and decisions of its agencies although it may not be directly involved in their work. Lines of accountability between agencies and the ministry vary among countries.

The number of agencies accountable to the ministry differs substantially across the five countries, as do their tasks and the responsibilities. Some agencies, notably the National Board of Health in Denmark perform a wide array of tasks ranging from monitoring the health system to planning hospital capacity and licensing providers, while other agencies, such as Pharmac in New Zealand, have only been created for a single, albeit important, purpose.

This report does not attempt to provide an exhaustive overview of all agencies involved in health system governance. The following list illustrates the range of responsibilities and tasks delegated to agencies:

(a) *Monitoring:* Several countries have equipped separate agencies with the task of monitoring population health, such as the National Board of Health in Denmark, the *Institut de veille sanitaire* in France and the Public Health Intelligence Unit in New Zealand. France and Spain have also created bodies to monitor the performance of the health system, the High Council of Public Health in France and the National Health Observatory in Spain. These organisations vary in terms of their degree of separation and independence from the ministry of health, but are generally designed to provide some assurance that the population health statistics produced are free from political interference.

(b) *Planning:* Capacity planning is currently delegated to the National Board of Health in Denmark, which is now responsible for approving plans for hospital care for each of the regions. In France, the Agency for Information on Hospital Care (ATIH) collects information on hospital planning, although regional hospital plans are approved by the Ministry of Health.

(c) *Administrative support to regions:* In several countries, agencies at central level offer technical or advisory support for activities delegated to the regional level. Examples are the Crown Health Financing Agency in New Zealand, which provides financial expertise to regional purchasers (i.e. District Health Boards) and the National Board of Health in Denmark, which runs the nationally uniform system of Diagnosis-Related Groups applied by the regions.

(d) *Provider licensing/certification:* In Denmark health professionals are licensed and certified by the National Board of Health. In New Zealand, hospital services require certification from HealthCERT, an external business unit of the Ministry of Health. In France, the *Haute Autorité de Santé* (HAS) develops and implements hospital accreditation procedures.

(e) *Pharmaceutical regulation:* Evaluating pharmaceuticals' safety and efficacy and issuing licences is typically delegated to subordinate government bodies, such as the Danish Medical Agency, the Federal Institute for Pharmaceuticals and Medical Devices in Germany and Medsafe in New Zealand. In France this responsibility rests with the independent *Haute Autorité de Santé.* New Zealand has also established an agency which is involved in pharmaceutical pricing.

(f) *Patient complaints:* Denmark and New Zealand have created bodies outside the ministry to respond to patients' complaints of poor quality care or professional malpractice (the Patient Complaints Board and the Complaints Board for Patient Injury in Denmark; the Health and Disability Commissioner in New Zealand).

(g) Other areas delegated to subordinate agencies are typically concerned with: disease control (National Serum Institute in Denmark; Robert Koch Institut in Germany); radiation protection (*Institut de radioprotection et de sureté nucléaire* in France and the National Radiation Laboratory in New Zealand); food safety (Food Safety Agency in Spain); health education (Federal Centre for Health Education in Germany); coordination and promotion of research

(Institute of Health Carlos III, Spain) and the organisation of screening programmes (National Screening Unit, New Zealand).

## *Role of regional governments*

The role of the Ministry of Health at central level is further shaped through the participation of regional governments in health system governance. The role of regional governments varies among countries, broadly mirroring a country's level of political decentralisation. In federal countries such as Germany and Spain, regional governments have substantial autonomy in organising and managing health care delivery. In Spain, regional governments oversee the entire health system and regulate almost all aspects of health care within their boundaries, except for limited national regulations (such as the core or minimum benefits package). Approaches to organising the health system also vary widely among regions. Regional autonomy has recently been enhanced by devolving further tax-raising powers from the centre to the regions. In Germany *Länder* governments are responsible for ensuring the provision of hospital care and developing legislation and hospital plans to this effect. National legislation does not give the federal Ministry of Health much room for intervention, except in cases that are explicitly defined.

In Germany and Spain arrangements are in place to improve the co-ordination of state/regional policies. In Germany the annual Conference of Health Ministers discusses and co-ordinates regional activities as they relate, mainly, to public health. Meetings are normally attended by the federal Minister of Health or by a representative of the Ministry of Health. In Spain, regional health policies are co-ordinated through the Interregional Council of the NHS (CISNS). This body provides a forum for regional governments and central government organisations. Its role has been strengthened in recent legislation (i.e. through the 2003 Cohesion and Quality Act). Although the central Ministry of Health is represented at the CISNS, it mainly acts as a co-ordinator and facilitator, illustrating the strong position of regional governments.

In Denmark, health care is mainly organised at regional and municipality level and is overseen by elected regional and local councils. Municipalities also raise their own taxes within a framework negotiated with the central government. In France regions (*départements*) have elected governments; however, regional hospital authority board members are essentially representatives of the Ministry of Health and liaise closely with central government organisations. District Health Boards in New Zealand operate within a framework of accountability set by the Ministry of Health and are accountable to the Minister of Health. The Ministry has retained the authority to replace District Health Boards if it finds that their performance is consistently failing.