NEW ZEALAND HEALTH STRATEGY DISCUSSION DOCUMENT

SUMMARY OF SUBMISSIONS

MINISTRY OF HEALTH

DECEMBER 2000

Contents

Executive Summary

The *New Zealand Health Strategy Discussion Document* was launched for public consultation by the Minister of Health on 1 June 2000. A two-month period was given for people to make either written submissions or oral submissions at a series of public meetings and focus groups.

A total of 24 public meetings, 13 hui, 4 fono and 20 other group meetings were held. Notes were taken at all the meetings and participants were told that these would be used as submissions. Approximately 1500 people attended meetings and a total of 466 written submissions were received.

The analysis of submissions has followed the format of the discussion document and submissions have been considered under each chapter heading. Overall there was positive reaction to the document and, in particular, respondents supported:

?? the development of a strategy
?? addressing disparities in health status
?? the proposed principles
?? the proposed population goals and objectives framework
?? the proposed service priority areas
?? urgent attention to workforce issues
?? more public participation in health decision-making
?? better information for decision-making and monitoring.

Fundamental principles

There was overall support for the concept of adopting an overarching set of fundamental principles for the health sector. People and organisations commenting on this approach felt that it was appropriate and there was broad support for the principles themselves. Comments were made on their visionary nature and the fact that they were aspirational. Some respondents questioned the capacity of the sector to achieve the principles and highlighted funding implications.

Although the principles were not intended to be in priority order, a number of respondents clearly felt that they were. A few commented that the principle addressing the Treaty of Waitangi should be moved to principle 1.

There was overall support for the individual principles, although there were comments on aspects of wording. For example principle 1, which talks about 'very good health' for all, was questioned as some people (eg, those suffering from a chronic disease) would never be able to achieve this. In discussing the

'disadvantaged' in principle 2, people questioned who should be included within the definition of disadvantaged.

In looking at additional principles, a number of themes were identified by respondents:

?? principles emphasising the intersectoral nature of the influences upon health status
?? principles around workforce issues
?? principles related to alternative therapies.

Goals and objectives

This section of the discussion document raised the greatest amount of discussion with approximately half of the written submissions and all public meetings addressing it directly. Almost all of these submissions supported the use of this framework to address action on health. This is evident across a broad range of responses from health providers, health care users, health support and advocacy organisations and local councils. Many respondents, whilst supporting the approach, also made suggestions for rewording goals or objectives or adding to the framework.

Some responses stated that the framework will only be useful if it leads to action. Evaluation and monitoring were seen as crucial to show progress. The Ministry of Health was urged to carry out further work relating to monitoring particularly around helping District Health Boards implement appropriate programmes and to monitor District Health Board performance.

Some respondents agreed with the goals and objectives provided there was room to allow local flexibility in choosing priorities and/or developing action plans to achieve them. Others, however, argued for consistency across the country.

There was particular support from some respondents for goals one to three and their associated objectives. Submissions argued that evidence pointed to the importance of addressing income, housing and education issues in order to improve the health of New Zealanders and reduce disparities in health status. Respondents stressed the importance of intersectoral action to address these issues, and noted the complexity of action required at central and local government levels.

There was considerable debate on the choice of priority objectives, with around one in three respondents suggesting additional priority objectives. These suggestions were wide-ranging and highlighted either population groups that respondents felt had been left out or specific areas they wished to be included. The population groups included:

?? older people
?? younger people

?? children
?? people in rural areas
?? immigrants and refugees
?? Pacific peoples
?? women with mental health problems.

In terms of specific issues, suggestions included:

?? asthma
?? complementary health care
?? sexual and reproductive health
?? unintentional injuries.

Service priorities

This section identified priority services that the Government wished to concentrate upon in the short to medium term. Most of the responses to this section tended to concentrate upon one or two areas rather than commenting across all. In each area there was overall support for the inclusion of that particular service area and many submissions made detailed comment. A number of additional service priority areas were suggested.

In public health there was overall support for this as a priority area –especially given the population focus of much of the document. There were concerns expressed, however, about adequate funding for public health and also the role of public health within a District Health Board structure which some feared would be dominated by secondary care issues. Some submissions advocated ring-fencing of public health funds together with national education and guidance for District Health Boards. Some submissions also emphasised that the difference between health promotion and health education should be made more explicit within the strategy.

All submissions on primary health care agreed that it should be a priority. The issues addressed were wide ranging from the need to see primary health care in its whole and not just a GP-based service, to issues concerning adequate funding. Some submissions pointed out that primary health care was important in furthering the aims of the strategy, in particular, population health. Some also highlighted barriers to accessing primary health care, including cost barriers and cultural appropriateness.

Reduced waiting times were supported as an objective although there was some concern over the maximum six month wait period from both providers and health service users. There was strong support for ensuring consistency of waiting times across the country and increased transparency for patients about how long they would need to wait for an operation.

The priority around mental health services received much comment. Again there was overall agreement that this should be a priority service but some issues were raised concerning what should be included within mental illness – for example, a discussion around services for people with dementia. Important points were raised concerning the need for greater integration of services between specialist health services and other agencies including non-government organisations; and also workforce development which many saw as crucial.

Many respondents felt the priority to advance Mäori health needed further consultation with iwi before firm decisions were made. It was seen as important that the process was driven by the community and not by the Ministry of Health or District Health Boards. Many submissions referred to the need for the forthcoming Mäori Health Strategy. Submissions also emphasised the need for more co-ordination of services for Mäori. Almost all responses supported Mäori advancement in health as a priority.

The majority of submissions commenting on the Pacific peoples health area also supported its inclusion as a priority. Many responses addressed the need for the development of workforce for Pacific services for Pacific peoples, and a few were disappointed that this had not been specifically identified. Difficulties of access were also mentioned as were the need for culturally appropriate services, particularly around language barriers.

There were suggestions for other service priority areas, mainly services for older people, youth, and complementary health services.

Quality

The document highlighted nine areas which contribute to high quality health services. All submissions commenting on individual rights believed that they were important. A number of additional rights were suggested: the most common was the right to the receipt of appropriate and accurate information relating to a patient's condition.

A small number of submissions looked at the overall requirement to ensure high quality services, and that to ensure appropriate monitoring mechanisms are in place. Submissions supported the need for improving co-ordination, both within the health sector and intersectorally. Many submissions supported the move away from a competitive model to a more co-operative one. Some submissions also pointed out that improved co-ordination tended to produce better outcomes but could be more costly, particularly in terms of time requirements by providers to work across 'boundaries'. A number of barriers to co-ordination were identified including issues around sharing information and confidentiality issues.

The problems facing rural communities and providers were commented on. The key issues related to transport, both for individuals and providers; to ensuring

equity of access for rural and urban people; and to workforce issues, particularly recruitment and retention of staff in more isolated areas.

A number of submissions commented on information issues, and all emphasised the importance of collecting high-quality, timely information. Some respondents also felt that reasons for collecting data needed to be made clear to ensure its relevance.

Comments on workforce issues tended to concentrate upon perceived shortages in the trained workforce and associated problems of recruitment and retention. This was felt to be particularly acute for Mäori and Pacific peoples' providers.

The remaining areas of this section concentrated upon general quality issues to ensure consistency and a high performing system. The tension between national consistency and local flexibility was noted. There was a good deal of support, however, for national quality standards and consistency. A common theme was the requirement for effective monitoring and evaluation of services to ensure that quality standards were maintained.

Consultation

Just over 40 percent of responses addressed consultation, and almost all agreed that consultation with the public and providers was important. In terms of providing information on consultation, many said that it was important to allow sufficient time for submissions to be made either at meetings or in written form. Respondents suggested a wide variety of means of providing information including advertising on newspapers, radio or TV, and working through community networks. Some noted the importance of making a special effort to reach people with special needs who do not normally come to meetings or prepare written submissions, for example, people from lower socio economic groups, youth, carers, Mäori, refugees and Pacific peoples. Many endorsed public meetings and written submissions as a means of providing feedback on key issues. In the context of District Health Boards, a number recommended standing community health committees, service advisory committees, and community liaison officers as a way for people to have a say.

Mäori Issues

Mäori issues were highlighted throughout the discussion document, and are analysed in chapter 9 of this report. There were a number of comments related to the Treaty of Waitangi and its use in the discussion document. It was felt by some that the Treaty section needed to be strengthened and more emphasis placed upon it. It was also suggested that partnership issues had not been addressed adequately within the discussion document and also needed to be strengthened.

A consistent theme of submissions from Mäori providers was one of concern with the new structural arrangements and, in particular, the introduction of District Health Boards. It was felt that the new structure may threaten the gains made by Mäori providers over the last 10 years. The importance of co-ordination for Mäori providers was emphasised, particularly given the holistic focus of Mäori health.

Some concentrated upon workforce issues and pointed out that recruitment and retention was particularly difficult for Mäori providers. A number of submissions pointed to the importance of the forthcoming Mäori Health Strategy.

1   Introduction

1.1   Background

On 1 June 2000 the Minister of Health, Hon Annette King, launched *The New Zealand Health Strategy Discussion Document*, setting out a proposed direction for action on health in New Zealand. The discussion document was released for a two-month consultation period with the sector and the wider public.

This report summarises key issues raised during the consultation period. These issues will be examined and taken into account in the redrafting of the Strategy.

1.2   Making a submission

The consultation period ran during June and July 2000. The views of consumers and providers were received in a number of ways. Four hundred and sixty-six written submissions were received either by mail, e-mail or logged online at the Ministry of Health's Web site. Sixty-one meetings were held with individuals, groups and the public.

A total of 466 written submissions were received. A number of meetings were also held are detailed in Table 1.

Table 1   Meetings held

Meetings	Number
Public meetings	24
Hui	13
Fono	4
Focus groups	16
Other meetings	4

Public meetings and hui were held in different centres across the country. Fono were held in Auckland, Christchurch and Wellington.

Small focus groups were held across the country. The specific focus group and their locations were:

?? public health non-governmental organisations – national group, Wellington
?? health promoters: Christchurch
?? health promotion forum: Auckland
?? youth issues: national adolescent health conference: Christchurch
?? older people: Wellington

?? Mäori: Wellington
?? local authorities: Wellington
?? Healthlinks: Porirua
?? disabilities: Wellington
?? caregivers: Christchurch
?? lower income: Christchurch
?? Asian: Auckland
?? Asian providers: Auckland
?? refugee health providers: Auckland
?? refugees: Auckland
?? chronic illness: Wellington.

The focus groups were chosen in order to gather information from groups that often do not attend public meetings and, in a few cases, in response to requests for meetings.

1.3 Responses to the discussion document

Written responses were divided into different types. There is a certain artificiality about this division as some groups or individuals can be classified in several ways. However, where this occurred the division was made by assessing the prime purpose of the group or individual in making the response, using information provided where possible.

Table 2 Percentage of written responses by groups

Academic	3
Consumers/health service user	20
Government agency	2
Health advocacy group	18
Health professional – individual	9
Health professional – organisation	12
Hospital and Health Service (HHS)	4
Mäori provider/organisation/service user	3
National organisation (most representing providers)	15
Natural health provider	4
Not clear	3
Pacific provider/organisation/service user	1
Territorial local authority	6
Total	100

1.4   Content of responses

The discussion document included nine questions to guide responses, but made it clear that the Ministry welcomed comments outside the confines of these questions. Many written responses addressed either all of the questions or, more commonly, those questions that they found most relevant to them.

The responses varied in complexity and the issues addressed. The length of the responses varied from just one or two pages that addressed just a few issues that the person or group thought were particularly important, to a small number of responses of more than 30 pages that addressed all or most of the issues raised in the document or other issues the person or organisation thought were important.

The content of meetings was often more fluid than written submissions, and most covered a range of issues including the new health system, with emphasis on the issues of greatest concern to the group.

1.5   Analysis of submissions

The written submissions and the written summaries from the meetings were entered onto a database. They were then coded in relation to the issues that they covered.

The coding was initially developed based on questions in the discussion document, and preliminary analysis of the meetings and early submissions. The coding schedule was later revised and additional codes created to cover other areas coming through in the submissions.

All major points of each submission were entered onto the database. Issues that did not correspond to the coding on the original databases were also entered.

The coding of data was checked by a different staff member to the one who had entered the data. Further spot quality checks were made throughout the analysis of submissions.

1.6   Reporting on responses

In essence this report is designed to:

?? report on the views of respondents to the issues raised in the discussion document and any other issues
?? identify all the major issues that both providers and consumers thought needed to be addressed in developing a successful strategy
?? identify any suggested solutions to problems identified by respondents

?? identify where different groups consistently held different views of the issues raised.

The analysis is thematic rather than quantitative. However, where a view is widely held or held by one group rather than another this is made clear. The report does not make any judgement on the accuracy or otherwise of the views expressed in any submission as this would be inappropriate. The purpose is to report on the views of those who made responses.

There are a number of reasons for adopting this approach:

?? not all respondents addressed all issues and the length and complexity of the responses varied considerably. Some concentrated on only one or two issues while others addressed them all.
?? the importance ascribed to a topic by respondents varied considerably.
?? many respondents were largely or totally concerned with their own experience or interest (whether as a group or an individual) while others took a wider perspective.
?? the people or organisations who respond to an issue were completely self-selected and do not provide a representative sample.

2. General Comments

About one in five responses commented on the idea of developing an overarching Strategy for health. Most were broadly supportive of the spirit and direction of the proposed Strategy. Some congratulated the Ministry or Minister on taking the initiative to developing an overarching strategy, and for opening it up for public discussion. Many supported the shift towards collaboration rather than competition, and welcomed more public accountability and input into the health system. Some supported the emphasis on promoting health and preventing illness.

It was pointed out that in order for the Strategy to be effective more specific action plans would need to be developed and implemented, otherwise it would just be yet another set of worthy words not leading anywhere. The importance of local involvement was reflected on, and ownership of problems and solutions to those problems.

> *Effective action relies heavily on strong and effective relationships at central and local levels.*

The style of the document was commented on, recommending:

?? the use of plain English
?? the addition of a glossary
?? clear diagrams.

Some respondents recommended that greater attention be paid to certain issues:

?? research: to inform action and evaluate impact
?? quality issues, particularly safety of services; monitoring and evaluation of policies/programmes; clinical governance
?? additional strategies not mentioned in the discussion document: public health; refugees, asylum seekers and migrants; mental health
?? therapies.

3.   Fundamental Principles

The discussion document proposed that a list of seven fundamental principles should be adopted to guide development of the sector. These principles would form the 'umbrella' beneath which other strategies would develop and would act as guiding principles for the sector as a whole.

The discussion document asked people to comment on:
?? the appropriateness of adopting a set of fundamental principles
?? the individual principles themselves
?? suggesting alterations or alternatives if they thought this was appropriate.

3.1   The use of principles to guide the health sector

More than half of respondents commented on the use of a set of principles to guide the health sector and almost all of these agreed with this approach. The majority also agreed that the principles within the discussion document were appropriate for this purpose.

A few people commented that the principles themselves were 'visionary'. In general this was felt to be a good thing as it sets aspirations for the sector and gives it a unity of purpose. Some people also commented, however, that visionary principles may also be difficult to monitor and measure progress on.

While there was general agreement with the principles there was a degree of doubt about whether these would actually be delivered in practice. A small number of people commented that resources should be available to ensure that adherence to the principles was possible. Some respondents also commented that it would be appropriate to have an enduring political commitment to the principles so that they would have a long life.

Some of the basic approaches underlying the development of the principles were supported in responses. These included:

?? greater recognition of the role of prevention and promotion in health services
?? emphasis on holistic health services and greater co-ordination
?? recognition of the importance of responding to the determinants of health.

A few thought that there should be fewer principles and perhaps a mission statement. Some commented that the principles were very general and could be open to various interpretations. This could leave them open to manipulation.

One group questioned whether it was appropriate for central government to be developing principles while at the same time it was devolving greater power to District Health Boards. They suggested that it would be more appropriate to develop a 'methodology' for choosing principles to guide District Health Boards. Another response thought that the principles ignored 'the really big things affecting the health debate' such as the role of nurses.

3.2 Individual principles

3.2.1 Very good health and wellbeing for all New Zealanders throughout their lives

Sixty-four submissions were made on this principle. Most agreed with this principle although a number felt that it was too idealistic. Some pointed out that some people in society may never be in a position to enjoy 'very good health'. Examples given were people with disabilities, with chronic diseases or those with terminal conditions.

> *This principle does nothing for people with severe illnesses or disabilities whom, with all the very best of care and attention, will never achieve 'very' good health and wellbeing.*

In rewording of the principle the most frequent suggestion was the removal of the word 'very'. Other suggestions were to replace 'very good' with 'optimal', 'maximising' or 'best possible'.

Although many respondents suggested that this principle was very broad, a few suggested that it should be broadened to include reference to the determinants of health that are outside the remit of the health sector and require intersectoral action. These included housing, employment, education and the environment.

A few focus groups and written responses suggested that the needs of some sections of the population (which were not easy to deal with in general statements) needed to be recognised in this section. Suggestions included refugees, children, Asian people or unborn children.

3.2.2 An improvement in health status of those currently disadvantaged

In addition to those in lower socioeconomic groups, Mäori and Pacific peoples were mentioned in the document. This principle was commented upon in 58 submissions, the majority of whom agreed with he principle. A number of

submissions commented that the phrase 'currently disadvantaged' should be defined. There were also suggestions for groups to be included with 'the disadvantaged':

?? disabled
?? children
?? older people
?? unemployed
?? the unborn
?? refugees
?? women.

A few submissions proposed strengthening the principle by replacing 'An improvement' with 'Actively closing the gap'.

There was some concern expressed that within a system with limited resources the improvement in the health of one section of society may imply a lessening of services for other sections of society. One submission wondered whether the inclusion of 'disadvantaged' implied that some were 'advantaged' in health. They asked whether these people would see a reduction in their health status.

3.2.3 Collaborative health promotion and disease and injury prevention by all sectors

Forty-nine submissions addressed this principle with the majority showing support. A number of respondents emphasised the intersectoral nature of this objective and the importance of collaboration across sectors outside of the health field.

> A well co-ordinated and sensibly implemented strategy for better health care, housing, education and welfare could make considerable gains in advancing health status.

A number of respondents commented that collaboration with other agencies including Land Safety Authority, the police, Accident Compensation Corporation and Occupational Safety and Health Service was necessary for this principle. Others also suggested the need for a wider range of agencies to work together on specific issues. For example, The Hillary Commission suggested 'Push Play with Active Christchurch' as an example which brings together Christchurch City Council, Crown Public Health, YMCA and the Heart Foundation.

Some of these respondents suggested that for effective collaboration and intersectoral working to happen, there needed to be effective leadership and resources made available:

> It is pleasing to see mention of the importance of collaboration. Working strategically across sectors is the key to addressing the wider determinants

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of health and safety. Collaboration, however, does not just happen. It requires leadership and co-ordination, both of which need to be funded and resourced (health professional organisation).

Some respondents observed that greater collaboration could be made between the health sector and providers of 'alternative' therapies. Others suggested that the principle was dominated by the understanding derived from a medical model rather than a holistic approach to health.

Other points raised included:

?? that there should be a distinction between primary medical care and primary health care
?? that many chronic illnesses could be prevented or ameliorated by using greater physical activity
?? the need to include people such as those with disabilities in the planning of these co-ordinated services.

3.2.4 Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay

Ninety-seven submissions commented upon this principle and it received strong support. Several responses felt that this principle was one that should underlie the whole health system.

We want to commend the recognition by this government of the importance of being able to access a comprehensive range of health services regardless of the ability to pay (as well as timely and equitable access) (health advocacy group).

The relationship between this principle and principle 2 was commented on, particularly with regard to the phrase 'regardless of ability to pay'. The links with Treaty issues in principle 5 were also noted.

A few queried whether ability to pay was referring to the Government's ability to pay for services or to individuals' ability to pay. A few noted that it would be difficult to achieve this principle within existing funding constraints.

The objective about 'within the resources' and the principle 'not limited by a person's ability to pay' seem to be in contradiction (Pacific peoples fono).

Some submissions noted that timely access may be very difficult, if not impossible, to achieve for some conditions. An example was diabetes where the best time for treatment was likely to be some years before symptoms were manifest.

Many respondents from rural areas (or from rural services) noted that ability to pay was not the only barrier for them. Availability of services was also a key issue in some rural areas.

Cost for the individual was identified as a major barrier to services. In particular, fee for service payments placed a barrier for some services such as dentistry, optometry, podiatry, pharmaceuticals and general practice.

Others, whilst agreeing with the principle, questioned whether there were available resources to be able to provide an undefined range of services. It was also noted that this would be difficult to achieve without greater co-ordination of services.

Other issues raised included:

?? lack of national criteria for access for certain conditions such as cancer
?? the need to include disability services
?? the need for cultural appropriateness of services for Mäori, Pacific peoples and immigrants
?? cost was a greater barrier for women whose incomes were lower than those of men.

3.2.5 Acknowledging the special relationship between tangata whenua and the Crown under the Treaty of Waitangi

Overall, there was support for this principle and a number of submissions argued that it should be higher up the list to emphasise the Government's commitment to the Treaty of Waitangi.

The (inclusion of the) Treaty of Waitangi in the New Zealand Health Strategy shows mature thought by this Government and its willingness to do what it can to alleviate the disproportionate suffering among Mäori (Mäori provider).

Some responses, particularly from Mäori, questioned the value of the principle as it stood. A few responses (including some from Pähekä) suggested replacing 'Treaty of Waitangi' with 'Te Tiriti O Waitangi' to emphasise the Mäori version of the Treaty; and to replace 'acknowledging' with 'upholding'.

A few Mäori providers questioned whether the development of the Strategy, and placing the principle at number five in fact reflected the true meaning of the Treaty. Speakers at one hui noted that the relationship should be between hapü and the Crown and that there were fundamental differences between the two documents (Treaty and Te Tiriti).

Some suggested that there was a need to show how this principle would be operationalised or 'given teeth'. This process might include participation of

Mäori in the development and promotion of the Strategy and the greater promotion and resourcing of Mäori services for Mäori.

A few individuals and groups questioned the inclusion of this principle. They felt that this could be seen as promoting special treatment for Mäori. One suggested that achieving principle 4 would make this principle redundant.

One submission from a service provider commented that information systems to accurately collect ethnicity data were vital if progress in health status for Mäori was to be measured.

3.2.6 A high-performing system in which people have confidence

Overall there was support for this principle with 56 submissions commenting upon it. The major issue raised in responses was that in order for people to have confidence, the system needs to be regularly monitored. A few recommended the inclusion of 'monitoring' within the principle. A number of submissions pointed out that the role of monitoring was particularly important here both to ensure that performance was maintained and also to ensure that people could have confidence in the system.

> *Without effective and meaningful evaluation, monitoring and auditing, which is transparent to the public, it is unreasonable to expect the public to have confidence in the system.* (Health professional organisation).

One submission argued that this principle was joining two separate concepts and that 'a high performing system' related to issues around effectiveness whilst 'confidence' related to acceptability of services.

Other issues raised included:

?? a need to recognise that a high performing system needs staff to deliver it
?? that people's lack of confidence in the system was caused by its commercial nature
?? that this was a key principle for improving Pacific people's health

> *Pacific people need to have confidence in a service before they will even think about accessing it* (Pacific peoples fono).

?? that this should include the availability of evidence and knowledge base for policy development
?? the need to emphasise a commitment to evidence-based procedures
?? the need to include 'stable' as a feature of the health system if people were to have confidence in it
?? some debate over what the terms actually meant or was defined.

3.2.7 Active involvement of consumers and communities at all levels

There were 50 responses to this principle and the majority supported the inclusion of this principle in the Strategy. A number of submissions commented that the principle needed to be made more specific so that they could be certain about what 'active involvement' meant. Several responses also pointed out that in order for this principle to be delivered effectively, it needed to be followed by concrete action.

> *Principle 7 should have higher priority given that health services will only be fully effective when well informed by active consumer participation. Health service planning and development processes that take account of local health needs and are designed to meet consumer needs are more likely to benefit consumers and be more efficient and effective.* (Government agency).

A number of responses felt that this principle should be strengthened by replacing 'involvement' with 'influence', 'impact' or 'participation'. One pointed out that the views of individuals may not necessarily be the views of communities and that different approaches would be required in order to involve both.

However, not all respondents thought that active consultation was always needed. One organisation felt that they were already over-consulted while others felt that people were usually happy to let the health care providers get on with the job.

> *This is an admirable statement, but provided there is general community acceptance of the direction being followed, many in the community will be happy and content to let those more directly involved get on with the job* (Territorial Local Authority).

Some respondents indicated what they would expect to see if this principle was followed.

?? District Health Boards willing to make changes to policy if there was strong opposition
?? consultation would involve 'more than just making submissions'
?? there would be a greater role for health service users in policy making, funding decisions and service development
?? the provision of funding to support adequate consultation mechanisms and individuals' involvement
?? sharing the results of any market research and similar consultations
?? the involvement of people from different cultures in the consultation process
?? regular communication with the community and different groups within it, for example, children and young people.

3.3 Additional or altered principles

People were asked if they would like to add or substitute a principle with another. A number of suggestions were made for how one or more principle could be added to or altered.

Several key themes ran through many of these suggestions. Some respondents noted that the responsibility for health was not that of the Government or the health sector alone. They wanted to see this reflected in the principles.

> *We would like to see the inclusion of an additional principle which underpins all the other principles. This principle should explicitly state that the health of New Zealanders is a shared responsibility. A responsibility shared by state, service providers and client/patient/individual. We would like this principle to convey a strong sense that attaining health is not a passive process but in many ways dependent on the actions of the individual (tertiary institution).*

A number also drew attention to workforce development and retention. Several variations on a principle to recognise the centrality of the workforce in the development of the health sector were suggested.

Several respondents suggested the inclusion of alternative or complementary health therapies as a principle. They discussed the role that alternative/complementary health has to play in the maintenance and development of New Zealanders' health.

A number of other alternative principles were offered. These included:

?? a focus on the ethics required to develop a structure which ensure community involvement and gives voice to the people affected
?? a greater emphasis on preventative health
?? a greater emphasis on interaction with other services which provide health services or impact on them such as territorial local authorities and Accident Compensation Corporation
?? protection of the vulnerable, for example, older people and people with disabilities. One respondent suggested 'freedom from social exclusion or negative discrimination on the basis of health status or disability'.
?? commitment to the provision of adequate resources to ensure health and wellbeing for New Zealanders
?? that all medicine and treatment should be based on sound evidence
?? a greater emphasis on the health of older people.

4   Goals and Objectives

The discussion document proposed nine goals which are the broad strategic statements to set the framework for achieving the New Zealand Health Strategy. Associated with each of these goals are a number of objectives. These will be used to set targets and performance measures.

People were asked whether they thought:

?? the goals and objectives provided a useful guide to improve the health of New Zealanders
?? the goals and objectives were important
?? other goals or objectives be added or subtracted.

Approximately half the responses, including most of the meetings, addressed all or part of the goals and objectives framework. Almost all of these supported the use of this framework to direct action on health. This support was evident across a broad range of responses from health providers, health care users, health support and advocacy organisations and Territorial Local Authorities.

> *Having a health strategy which provides an umbrella and philosophical approach for health is important to provide leadership, focus and direction in health related planning, developing approaches and the implementation of programmes and services* (Health advocacy group).

Many respondents made suggestions for rewording principles or objectives or adding to the framework. However, very few argued that the framework needed a thorough review.

Some respondents stated that the framework will only be useful if it leads to action, that responsibilities for action are identified, and that these actions are monitored and evaluated. Some were concerned that there was little detail about the funding they thought would be required to deliver the Strategy or about details on implementation. This was sometimes a theme at meetings where, although the general principles were supported, some people expressed a sense of 'déjà vu' .

A frequently raised theme was that monitoring would need to look at performance as well as outcomes, given the long time it can take to achieve changes in outcomes. SMART (specific, measureable, achievable, realistic, and timebound) targets needed to be developed to see which programmes achieve the desired results. The Ministry of Health was urged to carry out further work in this regard, particularly to help District Health Boards implement appropriate programmes, and to monitor District Health Board performance.

A number of respondents agreed with the goals and objectives provided there was room to allow local flexibility in choosing priorities and/or developing action plans to achieve them. Others, however, argued for consistency across the country. A few stated that goals and objectives would need to change over time as circumstances changed.

Some expressed their pleasure at seeing wider determinants of health addressed and the emphases on prevention, wellbeing and reducing disparities. These points were made by a number of territorial local authorities, health non-governmental organisations, public health providers, health professionals, health care users and other health interest groups.

There was particular support for goals one to three, and their associated objectives. They argued that the evidence pointed to the importance of addressing issues concerning income, housing and education in order to improve the mental and physical health of New Zealanders and reduce disparities in health status. A number stressed the importance of intersectoral action and noted the complexity of action required at central and local government levels.

Some Mäori providers and co-funders expressed some concern about the implications of the Strategy for Mäori. The placing or understanding of the Treaty was often the cause of this unease. The lack of detail on how the strategy would be operationalised was also a topic of debate.

A few proposed different goals to place a greater emphasis on socioeconomic determinants, rather than medical model or individual lifestyle approaches to health. A number advocated that goals should be set by population groups rather than by issues. Groups who they felt needed addressing and who might need goals included:

?? older people
?? children
?? young people
?? health care providers and users living in rural areas
?? immigrants and refugees
?? Pacific peoples
?? women (particularly in relation to sexual and reproductive health)
?? people with mental health problems.

Some also outlined areas that they thought had been inadequately addressed in the Goals and Objectives. These included:

?? the relationship of the Health Strategy with the Disability Strategy
?? the importance of individuals taking personal responsibility for their own health
?? need for greater openness to working with the private sector
?? the role of complementary health care

There was some indication that further prioritisation would be necessary, and that additional funding would be needed to support these priorities and this funding may need to be redistributed or increased for goals to be achieved.

4.1 Comments on individual goals and associated objectives

4.1.1 Healthy social environment

Thirty-eight respondents specifically addressed this goal and the four associated objectives. None opposed the goal or its associated objectives, but a number made recommendations for changes to the wording or inclusion of other objectives under this heading.

Several pointed out that unemployment was an issue which should be addressed by an objective, given its association with poverty or reduced self- esteem. Another recommended objective was 'to reduce [eliminate] social exclusion, or discrimination against people on the basis of their health status or disability'.

Some indicated that the wording of the objectives should be strengthened as 'support' was simply not strong enough. One recommended that this was necessary if the appropriate workforce was to be developed.

4.1.2 Healthy physical environment

Thirty-nine responses specifically addressed this goal and its associated objectives. There were no objections but a number made recommendations to include other objectives under this heading.

Respondents, primarily from people with an interest in natural therapies and a small number of health professionals, recommended that more goals or objectives be set regarding environmental health. These were specifically with respect to hazardous substances and chemicals (such as pesticides, artificial colourings, fluoride, artificial fertilisers), genetically modified foods and food additives. Concerns were raised regarding the impact on the immune system of such substances. There were recommendations that organic food be promoted.

Some recommended inclusion of objectives relating to biosecurity, housing (for older people and Pacific peoples), air and noise pollution and breastfeeding.

The important connections between objectives under this goal and objectives for goals 4 to 9 were noted. For example, the importance of safe, secure physical environments and exercise, the connection between good nutrition and good oral health, the connection between income and access to healthy food, the connection between exposure to environmental tobacco smoke, excessive UV radiation and cancer. A number of responses indicated the importance of

District Health Boards engaging with local government to achieve these objectives.

The government's stated intention to improve water and sewage schemes in poorer rural areas was supported.

4.1.3 Healthy communities, families and individuals

Forty responses specifically addressed this goal and its associated objectives with most comments focusing on objectives 9, 12, 13 and 14. None opposed the goal or its associated objectives, but recommendations were made for changes in wording under this heading. For example, the addition of 'social cohesion' to objective 9 was suggested.

Some provided support for action on the objective/s related to the goal. A number of submissions commented on the importance of community development to improve health.

> *Community development in action in the health sector offers an alternative way of working with people to bring about positive changes in their health status. It involves traditional institutions and services working with the community by providing them with the resources needed to bring about change. When people are given the opportunity to be involved in identifying their own health needs from the ground up; when they are involved in decision-making about their own health needs; and when they are given full and continuous access to professional expertise, information and learning opportunities, they are empowered to be in charge of their own lives* (territorial local authority).

Many groups supported the involvement of communities and population groups in health decision-making and service delivery. This support came from many different types of respondents, particularly health service users, non government organisations, advocacy groups, territorial local authorities, Mäori, Pacific and public health providers.

Some respondents focusing on the needs of Mäori, Pacific peoples and youth reflected on the importance of involving these groups themselves in identifying key health problems and solutions to such problems. This argument was frequently raised as an important issue for District Health Boards to consider.

Respondents stressed the importance of intersectoral action to improve health outcomes, particularly for children from disadvantaged backgrounds. This was suggested as a top priority as it would improve outcomes for the child throughout their life, not just in childhood. Many of these cross-referenced to the Child Health Strategy and confirmed their support for its implementation.

Respondents also emphasised the importance of objective 13 (support for caregivers) and objective 14 (support for positive ageing policies and programmes). Some noted the preference that older people had for care in their own homes, and therefore the need for good community-based services and for respite care for caregivers to reduce the current excessive burden some experienced. A few suggested rewording for the caregivers objective to include care in the community.

Key actions necessary to achieve the objectives were expanded on, or it was pointed out that it was important to identify the 'how, who, what and when' relevant to these objectives.

Other issues raised included:

?? the important role that health education and promotion could play in the health of individuals and groups
?? the role of complementary care in maintaining health for families and individuals.

4.1.4 Healthy lifestyles

Thirty responses specifically addressed this goal and its associated objectives. There was no opposition, but there were recommendations for changes in wording under this heading. However, there were no common themes across responses regarding changes to the wording.

Objectives 17 (physical activity) and 18 (sexual and reproductive health) attracted most comments. This was mainly either support or the provision of details concerning the design and delivery of programmes to address these objectives. A small number of a few respondents were critical of either the 'easy' availability of abortion or the Family Planning Association in this context. A few submissions emphasised the importance of sexually transmitted diseases (STDs) being considered within objective 18, and noted that this objective should be included in the priority list. Several recommended a separate objective for obesity.

A few respondents also pointed out the importance of avoiding victim-blaming. They often stressed the importance of addressing goals 1 to 3 as priorities.

4.1.5 Better mental health

Fifty responses specifically addressed this goal. The objective to improve the health status of people with severe mental illness attracted the most support. A few responses also pointed out the importance of good mental health in its broadest form to overall health status.

Promoting mental health is a key issue now and in the future. Positive mental health will need to be addressed if the six objectives under the goal are to be achieved. Mental health is increasingly acknowledged as an essential component of the wellbeing of populations.

There were more recommendations for changes to these objectives than for those in other goals and a wider variety of opinions on these issues. Many of the comments and recommendations related to personal mental health services provision rather than the promotion of mental health, prevention or early intervention.

Attention was drawn to the importance of the relationship between this goal and others, particularly goals 1 to 3, in the maintenance of good mental health. This was often expressed as support for healthy schools, workplaces and communities; supportive communities; family support; income and increased employment.

There was some support for separating the needs of those with moderate or severe mental health problems from the wider population based services such as promotion. The response from the Mental Health Commission suggested that two primary objectives could be adopted for this goal:

?? to improve health status of people with severe mental illness (with sub objectives for suicide, dementia and depression)
?? to improve health status of people with mild to moderate mental illness (sub-objective stress).

The Commission saw objectives 23 (improve health status of people with severe mental illness), 25 (stigma), and 41 (services) as having greater priority than others.

Some pointed out the importance of investing in good mental health in the early years of life, including meeting the needs of parents or parents to be, as this would have a lifelong impact. A few responses also referred to a link between poor mental health care and crime.

A few respondents did not support the objective for dementia, pointing out that very little was known about its prevention, and that a lot more research needed to be carried out before programmes could be introduced. Some questioned its placement under this goal.

Other issues included:

?? a perception that the mental health of youth had not improved as much as that of adults over the last 30 years
?? a concern about the lack of mention of alcohol and drugs
?? a concern that the role of non government organisations in delivering mental health services was not recognised

?? the importance of promoting the community's understanding of mental illness
?? a concern that all the five associated objectives had a medical focus rather than an holistic perspective which acknowledged non-clinical intervention as a valid component of services.

4.1.6 Better physical health

Twenty-three respondents referred to this goal and its associated objectives. There was very little disagreement. Comments mainly related to the addition of new objectives, ways of achieving objectives, or rewording of objectives.

Suggestions for additional objectives included:

?? sleep disorders
?? immune-related disorders
?? peripheral vascular disease
?? obstetric and gynaecological issues.

Individual suggestions for changes in wording included:

?? specifying children and young people for objectives relating to oral health and infectious diseases (given that the burden falls disproportionately on these age groups)
?? considering whether communicable disease is a better term than infectious disease (in the context of Hepatitis C).

4.1.7 Fewer injuries

Thirty-three responses addressed this goal and its objectives. Most were broadly supportive with some suggestions for rewording objectives, particularly with respect to unintentional injury in children and youth. Several responses proposed an additional objective should be added on sports injuries or to cover workplace injuries.

Some recommended an improvement in injury surveillance data in order for programmes to be well-designed and monitored.

It was sometimes pointed out that unintentional injuries far exceed intentional injury as a cause of death and hospitalisation, especially for children. These responses often suggested some rewording of objective 36 to highlight this fact. They felt such injuries are predictable and easily preventable, and therefore they should be a higher priority than the interpersonal violence objective. On the other hand enthusiastic support was given to the interpersonal violence objective as a priority, pointing out that violence has a major impact on health beyond physical injury.

4.1.8 Health care services

Seventy-nine responses addressed this goal and its objectives. There was widespread support for improving appropriate access to services. A number of responses pointed out that access was a multifaceted issue, covering affordability, availability, accessibility, accommodation and acceptability.

The issue of transport was raised, particularly with respect to rural areas and older people. It was suggested that specialists should be encouraged to travel to their patients, rather than always expecting people to come to them.

There was some support for having an objective for specific services for youth given the fact that youth do not access ordinary health services very frequently, despite need. Others also recommended a specific objective for services for older people which would include assessment, treatment and rehabilitation services. Some recommended the inclusion of services for people with disabilities as an objective.

Additional objectives included the inclusion or improvement of a number of services. These were:

?? maternity services
?? palliative care
?? information about service availability and quality
?? acute medical services
?? postnatal care
?? services for rural communities
?? family planning.

Several respondents criticised the wording of objectives and pointed out the impracticality of such broad objectives or wording. They asked how can you 'ensure' or answer patient expectations for instant treatment.

Several pointed out an anomaly between Accident Compensation Corporation and health funding. They asked why should people with 'self-inflicted' sports injuries receive benefits that people with a disability cannot access?

The importance of population needs assessment in the context of provision of health services was also commented on.

4.1.9 Mäori development

Thirty responses addressed this goal and were broadly supportive. Comments were wide ranging.

Several referred to the Treaty as being the key reference point for action on health for Mäori, and debated relevant issues concerning that objective. The

responses wished the New Zealand Health Strategy to clearly express the special relationship that Mäori have with the Crown.

Several also highlighted the importance of objective 49 (information) to this goal, including the recording of ethnicity data. This information was essential to help identify Mäori needs and to measure the impact of the Closing the Gaps project.

Other issues mentioned included:

?? support for traditional Mäori healing methods being included in objectives
?? the whare tapa whä model
?? the importance of making mainstream services more accessible for Mäori
?? the importance of prevention
?? the importance of recognising different types of partnerships for service delivery developed by local communities.

5   Priority objectives

The discussion document proposed 12 priority objectives for immediate action, and asked people to comment on the choice of priorities. This section of the document attracted considerable comment, with over half of respondents addressing one or more of these priorities. Two-thirds of those who commented were happy with the proposed priority objectives and made few other comments.

Some wished to see some changes in one or more of the priorities. These changes included rewording an objective, the substitution of another objective in place of the chosen ones or the addition of another priority. Most only suggested one or two additional objectives or changes rather than a large scale rewriting of the proposed priority objectives.

Some agreed that it was important to identify and act on priorities and a few commented on the need to further hone down the number of these priorities. These respondents often thought that it would be difficult for District Health Boards to deliver on such a wide range of issues.

A few thought that the criteria used for selecting priorities should be identified and explained. Some doubts were expressed about the methodologies used by the committee or the professional backgrounds of these people. An 'over-reliance' on epidemiology was sometimes mentioned.

Around one-third of these respondents recommended the addition of other priorities, but few of these suggested that this new priority replace one already on the list. The most common areas of debate were the objectives for intentional injury and the reduction of suicide. Some argued that unintentional injury in children was a much more significant issue, and that there was more evidence concerning effective action to prevent this from happening.

Eighteen responses suggested that the priority objectives should be predominantly drawn from goals 1 to 3 (social and economic determinants). The current list of priorities, it was said, were too disease/medically focused. These people thought that the choice of these objectives for action on these determinants would have greater impact on the health of the population than some of the other chosen priorities.

Some respondents recommended objectives for specific additional population groups. Seventeen respondents recommended a priority objective for older people, and often supported the development of a specific strategy for older people. Similar number of responses supported a greater emphasis on children in the objectives or that specific priority objectives should relate to youth. These often supported the development of a health strategy for youth.

Sexual and reproductive health (in its broadest sense) and asthma were the health issues most commonly mentioned as additional priorities. Breastfeeding, depression and infectious diseases were supported as priorities.

The inter-linkages between the proposed priority objectives (for example, exercise, nutrition, smoking and heart disease) was noted by a few. Others stressed the importance of action plans with measurable time-limited targets if the priorities were to move from statements to realities.

A few issues were raised about the role or number of the priority objectives. These included:

?? a question on whether there were not too many objectives
?? some perceived a poor relationship between the principles and the objectives while other responses thought these were essentially the same
?? some thought the principles and objectives were too general.

5.1 Mäori and Pacific health disparities

Sixty-six responses addressed this priority objective and almost all responses were supportive. A few recommended that this objective should be extended to other New Zealanders from lower socioeconomic groups. Several recommended that the needs of refugees, asylum seekers and new Asian immigrants be addressed under this objective.

> *While Mäori and Pacific people have relatively significantly poorer health, numerically Päkehä people are the majority, therefore, there will be greater absolute numbers of Päkehä people with adverse health statistics* (Health advocacy group).

Other comments mainly related to specific issues that need to be addressed to reduce inequalities in health. There was support of the planned development of a Pacific Health Strategy in consultation with Pacific health care providers and service users.

5.2 Smoking

Twenty responses addressed this objective and all were supportive. Most of the comments mainly related to the nature of programmes for example, Chinese traditional medicine, that should be implemented to address this issue. Two suggested the inclusion of reducing marijuana use.
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5.3 Nutrition and obesity

Thirty responses addressed this priority objective and all were supportive of the inclusion of nutrition and obesity. A few recommended listing these as separate objectives. These observed that obesity does not just relate to diet but also to lack of exercise, or that good nutrition goes beyond the issue of obesity to other issues such as a balanced diet (impacting on disease such as diabetes and heart disease).

Several submissions warned that the issue of obesity must be dealt with appropriately, given the guilt and anxiety associated with being obese and its connection with eating disorders. One response suggested that 'Healthy at every size' is an appropriate key message.

Other comments included:

?? the adverse impact of marketing and advertisements on diet
?? because of the cost of healthy food it was more difficult to purchase for people on a low income
?? support for the promotion of organically grown food.

5.4 Physical exercise

Twenty responses addressed this priority objective and all were supportive of this as a priority. Most of the comments related to the specifics of designing programmes. Several added that promotion should focus on safer forms of exercise or avoid concentration on elite sports. One suggested that some of the public programmes currently being used to promote physical activity, while 'well meaning' had limited efficiency. This recommended the use of experts in the design of programmes.

5.5 Suicide

Thirty responses addressed this issue.

Some indicated that it would be far more appropriate to prioritise on appropriate youth health services (well connected with mental health services and other social services) in order to help meet youth needs than to identify a 'relatively rare' outcome of mental problems.

Some of these suggested that addressing depression was a more important priority. If this were addressed they thought this would in turn impact on the rate of suicide. A few, suggested that suicide should be an indicator of the success of general mental health programmes for young people rather than a specific area in itself.

Some responses stated the importance of addressing objectives concerning socioeconomic determinants if suicide were to be addressed. They saw

unemployment, education and poor family relationships as among the causes of suicide that needed to be addressed in more generic programmes.

5.6 Alcohol and other drugs

Thirty responses were made on this issue, all in support of its inclusion as a priority. Alcohol was the drug of most concern, followed by cannabis.

Several respondents emphasised the importance of including the prevention of foetal alcohol syndrome in this objective. Several specifically opposed the decriminalisation of cannabis.

The Government's role in dealing with alcohol abuse was debated in a few responses. One congratulated them for 'grasping the nettle' relating to advertising and promoting alcohol. However, a few criticised Parliament for lowering the drinking age to 18 years.

5.7 Cancer

A small number of responses addressed this issue, all in support of its inclusion as a priority. There were few common themes across the submissions, although several mentioned the need for a cancer strategy or control programme and several mentioned the importance of adequate screening programmes.

5.8 Cardiovascular disease

Ten responses specifically addressed cardiovascular disease as a priority, and all but one were in agreement with its inclusion as a priority objective.

5.9 Diabetes

There were 20 responses, all in agreement with diabetes as a priority. Most comments related to reasons for their support or to details of how to increase the efficacy of prevention, screening or treatment programmes.

5.10 Oral health

Thirty responses were made on this priority objective, all but one in support. Many of these comments referred to the affordability of oral care in terms of costs of accessing dental services. Cost was identified as a major barrier for young people, Mäori and Pacific peoples, the unemployed and other people with

low incomes. One response suggested that 80 percent of oral health care was taken up by just half the population.

One Hospital and Health Service noted that dental caries was the commonest disease in children in their region and the commonest cause of hospitalisation. They thought that this was an almost completely preventable disease and potentially a very achievable goal. Another HHS agreed on the importance of oral health, particularly for children, but thought that it should not be a goal.

5.11 Violence

Thirty responses were received and all supported this as a priority.   One organisation stated how pleased it was to see that violence had been accepted as a major priority by the Government and hoped that this would be accompanied by a raft of appropriate measures including population education. While several mentioned youth in particular as the subject of violence towards older people were was mentioned.

However, a few questioned whether this was an appropriate priority objective. It was noted that many other government agencies were also involved in violence prevention programmes. They wondered whether it should therefore be a priority for Vote Health. Several argued that unintentional injury should be given a higher priority, given its higher incidence and the greater ability to do something about it.

5.12 Child health care and immunisation

Thirty-five responses were received on this priority objective, all of which supported child health as a priority. A few were opposed to immunisation as a priority while others stressed the importance of raising immunisation levels.

Other issues raised included:

?? the need for the implementation of the Child Health Strategy as a priority
?? the importance of addressing unintentional injury in children
?? the importance of databases on child health, for example, on immunisation status
?? the importance of support for families.

6   Service Priorities

The discussion document identified improving access to five services and prioritising services for Mäori and Pacific peoples as service priorities that the Government wished to concentrate on in the short term. People were asked whether:

?? they thought that it was important to improve access to these services
?? what were the key issues that the Government should concentrate on in each area
?? other services that needed to be improved in the short to medium term.

Approximately two thirds of responses addressed one or more of the priority services. Many of the meetings, eg, the hui, fono or the focus group for service providers for refugees only focused on one or two services relevant to the people attending that meeting.

Some suggested the addition of other services but there was little opposition to those that had been included. The focus on services for Mäori and Pacific rather than on all people with low health status or low incomes was questioned.

Some Hospital and Health Services and other respondents questioned the wisdom of treating service priorities and health goals as separate issues. They believed that the impact of one on the other was inseparable and the Strategy would need to consider this in its final form. One tertiary institute thought that the possible impact of addressing one priority on the others should be made explicit, eg, the effect that a focus on waiting lists would have on other service priorities.

Some observed that availability of services were not the only barriers to access in New Zealand. Many other barriers were noted including:

?? financial barriers for people with low incomes. This was identified by some as the greatest barrier to access. They thought that for the Strategy to be successful it would need to address this issue in depth
?? lack of a suitable workforce, eg, nurses, community care staff
?? lack of information about available services
?? lack of transport
?? language barriers.

6.1   Public health

Forty-nine responses discussed the inclusion of public health services as a priority service and all but one agreed that this service was an important priority. A wide range of providers responded including public health professionals, advocacy and support groups. Twelve health service users and a few territorial local authorities also addressed this service priority issue.

It was recommended that public health services needed to focus on specific areas. These included services for population groups such as school children, older people and Mäori. Others suggested specific areas which included mental health, alcohol abuse, reproductive services and the promotion of greater physical activity.

There was some concern about the wording used to discuss public health in the document in two areas. This was often from public health professionals and from health service organisations such as Hospital and Health Services. These were:

?? public health professionals, in particular, thought there was potential confusion between publicly funded services which included primary and secondary services and public health services. This confusion could impact on attempts to 'brand' public health as a separate service
?? there needed to be a distinction between health promotion with a population focus and health education with an individual focus.

The need to continue the ring-fencing of funding of public health services was raised by some. There was sometimes concern that there was already too little funding for public health and these recommended an increase in funding for public health services.

A concern about the future role of District Health Boards was often driven by concern about their future role in the delivery of public health services. This concern was based partly on the history of area health boards and Hospital and Health Services. There was also concern that District Health Boards would become focused on secondary care issues such as reducing waiting lists rather than public health.

DHBs will need education and guidance on public health issues through mechanisms which could include regional networks for planning and funding, provider groups and networks meeting with NGOs (non-government organisations) and training for DHBs on public health approaches.

Some respondents were also concerned that primary health organisations (as described in the primary health care discussion document) would become responsible for population public health services. These responses, often from public health professionals or health advocacy groups believed that primary care providers may not fully understand public health.

However, two respondents saw an important role for primary care providers in public health as long as this did not replace existing public health services. These responses were among several who were concerned about duplication of public health services between the different sectors that provided these services.

Many identified the need for greater intersectoral co-operation in the future to underpin effective public health services. Other agencies seen as important

contributors to public health included territorial local authorities, education providers, housing providers and workplaces.

Several also stressed the need to incorporate the community as well as health care providers in the future planning and delivery of public health services. This would necessitate ongoing consultation with other bodies and communities.

Other issues raised included:

?? that it was sometimes necessary for public health providers to take a strong stand on an issue that was a potential embarrassment to their employers (eg, District Health Boards). The right to do so needed to be protected in legislation.
?? several responses, again usually from public health professionals, saw the need for a separate Public Health Strategy to be developed that would underpin the New Zealand Health Strategy.

6.2   Primary health care

Eighty-five responses addressed the inclusion of primary health care as a service priority and all agreed that this should be priority. However, a few thought that health promotion should not be included as a primary health care service. A few noted that they had already made a submission to the discussion document on primary health care earlier in the year. Some of these revisited issues that had been raised in that consultation.

Some were concerned that primary health care should not be seen as only those services delivered by general practice. Nurses in particular were identified as significant providers of primary health care services and the advantages of utilising nurses in the delivery of population- focused services was noted.

Areas were identified where it was felt primary care needed a greater focus. These included asthma and respiratory complaints, services for Mäori and Pacific peoples, school health services (provided by nurses) and maternity services. A few responses felt that primary health care needed to make a greater focus on population services such as health promotion and disease prevention.

There was support for a greater focus on primary health care because they believed that the effective delivery of these services would have an important role in reducing the demand for hospital services. One noted that this could then lead to more beds being available, thus allowing hospitals to carry out more elective surgery.

Adequate funding for primary health care services, or the lack of this, was seen as an issue by some including those from providers and advocacy groups. Some of these supported an increase in funding because they thought that this

area was most likely to have an impact on the health status of New Zealanders. The possibility that it could lead to a reduction on spending for secondary services was also noted.

Barriers to access to primary care was noted. The major barriers were the cost of co-payments for visiting GPs or the cost of pharmaceuticals.

At least weekly I come across people under pressure financially to purchase prescriptions or make GP visits. Many put off a visit to the GP or obtaining the prescription for too long and end up with more serious problem. (General Practitioner).

There were suggestions to reduce these barriers. The main ones were:

?? that GPs should use capitation rather than fee for service, usually for people on low incomes. One GP identified capitation as the best form of charging for refugees
?? doctors and their services should be salaried by the state
?? the income levels for the Community Services Card should be increased

Other barriers to access were identified that was felt had not been adequately identified or addressed in the document. These included cultural inappropriateness of some services, lack of information on services and health needs, unavailability of services in rural areas and transport difficulties.

A number of other issues were raised during discussion of access to primary health care services. These included:

?? the need for greater co-ordination between different primary health care providers and between the primary and secondary sector. This was expected to lead to a reduction in the duplication of services
?? the importance of monitoring and audit for primary health care services
?? a concern that District Health Boards would focus on secondary services
?? the advantages of 'one-stop shops', particularly to increase the effectiveness of prevention strategies.

6.3   Reduce waiting times for public hospital elective services

Fifty-nine responses addressed the reduction of waiting times for elective surgery and the associated key objectives and seven strategies. Some of these objectives, such as the goal of a maximum six-month wait and giving patients certainty were more likely to be commented on than others.

It was agreed that reducing waiting times was an important goal but there was some concern over the maximum six-month wait from both providers and health service users. There was concern that some conditions or procedures such as cancer therapy and evaluation or angiography went on waiting lists at all. Other

responses, often from health service users, observed that while some conditions such as hip replacement and cataract operations were called elective they caused considerable distress to people in need.

Several respondents highlighted problems they saw arising from waiting lists that should be addressed but were not covered by the document. These included:

?? there were often waiting lists for community services such as district nursing
?? those caring for people on waiting lists sometimes also needed assistance
?? waiting times for initial assessment by specialists were too long
?? the need for older people to be seen in a very short period of time

There was strong support for ensuring consistency of waiting times across the country and increased transparency for patients about how long they would need to wait for an operation. Some, however, suggested a need for caution. One noted that nationally consistent assessment criteria were being developed at present and they did not wish to see this work abandoned. They also observed that while giving patients certainty was a laudable ideal, emergency operations would always take priority and that it would be difficult to guarantee firm dates. One health service user observed that health care providers and funders had been working on developing nationally consistent assessments for years and that achieving a national consensus would obviously be difficult.

The shortage of an appropriate workforce to carry out elective surgery was also identified as a potential difficulty. Major problems identified included a shortage of available staff and nurses in particular, and the increasing move by specialists into the private sector.

It was noted that an improved primary health care service, as outlined in the second services priority, could assist the reduction of waiting lists in two ways. More simple operations could be carried out in general practice by primary care providers. More importantly, more effective community services and primary health care services could prevent some conditions from ever developing in the first place.

Other points noted included:

?? improving performance in this area was essential to increase public confidence in the health system
?? there should be an increased emphasis on caring for people while they were on waiting lists to keep them in optimum health
?? better co-ordination between primary and secondary services was necessary for the reduction in waiting lists.

Some suggested that too much emphasis was being placed on waiting lists. One observed that waiting lists were valuable management tools. Several were concerned that that an over-emphasis on waiting lists would possibly lead to reduced resources for community and primary health care services.

*We see a potential conflict between the priority to reduce waiting lists and other priorities and this risk is heightened in the light of general community values (focusing on) glamour and high profile medicine…. be at the expense of other equally important but less visible or emotive services such as health promotion and continuing care (*educational institution).

6.4 Improving the responsiveness of mental health services

Eighty-six responses addressed the need to improve the responsiveness of mental health services. All responses agreed that this was an important service and in need of development. There were, however, some differences about which services needed to be developed or in what way.

Alcohol and drug services expressed some concern that this area had not been identified as a goal or priority service although it was identified as a priority objective. There was some unease that these services were being subsumed under mental health services. Other concerns was there should be adequate services for people with schizophrenia and dementia.

Many addressed one or more areas where they felt that the level of mental health services were inadequate at present. These often came from groups of providers or health service users interested in a specific area, and included:

?? mental health services in rural areas
?? culturally appropriate services for Mäori and Pacific peoples, some of whom were unaware of available services
?? specialist services for older people and young people
?? adequate services, such as respite care, for families caring for people with mental health problems
?? adequate sheltered accommodation and staffing for people with mental health problems to enable them to live in the community
?? services for women with postnatal depression or psychosis
?? adequate research, eg, on the mental health needs of women who have had abortions.

A number of ways in which the current level of services could be improved were identified. The most common were an increase in the adequacy of 'halfway houses' and of support services for people with mental health problems so they could live in the community.

As family members we would like to see the mentally ill with proper care and support living in an environment that allows them to live lives of value. There is a need for staffed sheltered apartments and 24-hour care where people are accountable. We ask for the Mason Report No 1 to be fully implemented in all aspects (Health advocacy group).

There was also strong endorsement of the need for greater integration of services between the different services provided by health agencies, other community services, non governmental organisations and services supplied by other agencies. Some saw increased co-ordination as particularly important if primary mental health services (eg, promotion, early intervention and rapid response teams) were to be improved. Co-ordination was also seen as important to ensure the safety of the workforce.

The development of an appropriate workforce was another area seen as critical for the improvement of mental health services. Several references were made to the need to complete already planned development of the workforce. An increase in the capacity of primary care services such as general practice and health promotion was seen as a vital way to support people with mental health problems to live in the community. The need for increased levels of funding, often related to the development of an appropriate workforce was also often raised as being important to increase responsiveness.

Other issues were also identified as important for increasing the ability of mental health services to respond. These included:

?? an increase in residential services for people with severe mental problems. Some thought that there was an over-emphasis on community treatment
?? one respondent thought that the numbers of people in mental hospitals would be reduced if the art of exorcism were rediscovered
?? a mental health consumers group identified a need to increase the ease of voluntary admission as a key necessity. They were concerned that without this the condition of some people deteriorated unnecessarily
?? a greater role for mental health consumers in the design and provision of services.

There needs to be an allowance in the new system for the greater involvement of consumers in both policy making, funding processes and service development, and ultimately in moving towards more consumer focused services (Mental Health Commission).

6.5 Mäori advancement in health

The document identified a number of ways that Mäori health status could be improved though the development of services. This included the growth of the

Mäori workforce and enhancing mainstream providers' ability to respond to Mäori needs.

Ninety-three responses addressed this priority. Many were from Mäori and included those who attended the seven hui, Mäori providers and co-funders.

Some Mäori respondents indicated that they thought there would need to be further consultation with iwi before any firm decisions were made about the nature of services for Mäori. It was seen as important that this process was driven by the community, not by the Ministry of Health or by District Health Boards. These responses often also referred to the need for the proposed Mäori Health Strategy.

The need for concentrating on capacity development was also endorsed. A few respondents provided descriptions of what a Mäori service should look like in order to be eligible for funding.

> *Mäori providers have to be defined as those aligned with traditional iwi groups, preferably based on or near a marae and providing a wide range of health services in order to be recognised as an 'appropriate' Mäori provider, and therefore eligible for provider development funding* (Mäori health provider).

There was also support for greater co-ordination of Mäori services. These services included Mäori health providers, mainstream health service providers and providers from other sectors. It was noted that some of the causes of Mäori ill health were to be found in areas like housing, employment and welfare, and any effective responses needed to involve providers from all of these sectors.

There was some concern from Mäori that the implications of the Treaty of Waitangi had not been properly understood in the document. Issues raised in this context included:

?? a need to maintain and develop partnerships with Mäori co-funding organisations such as Mäori Development Organisations (MDOs) and Mäori Provider Organisations (MAPOs)
?? a recognition that the reason for prioritising Mäori services should be seen as a treaty obligation
?? that the articles in the Treaty are about rights and responsibilities, not about 'forming partnerships' as outlined in the document.

There was concern expressed about some of the Mäori wording used in the document. For example, speakers at two hui felt that the use of the word 'mana whenua' was inappropriate and they preferred tangata whenua or hapü.

Many responses commented on the eight priority areas that were identified in the document. The need for appropriate and well-trained mental health services was particularly endorsed. Most of these, which often came from organisations

with a particular concern with a specific area, thought that one or more additional conditions or treatments of high concern to Mäori should be added to the list. Areas identified included reducing smoking, palliative care, epilepsy, asthma, maternal care, and screening for infectious disease such as hepatitis.

Almost all supported the idea that Mäori advancement in health should be a priority. However, some, while accepting that Mäori health needs were high, felt that the Strategy needed to recognise the high health needs of other groups, such as Pacific peoples and people with low incomes.

6.6   Improving Pacific peoples' health

The document identified the need to improve the health of Pacific peoples and outlined areas to be further developed in a Pacific Health Strategy. Fifty- two responses addressed this topic. Some of these were from Pacific providers and health service users.

The document identifies five priority areas where services for Pacific peoples need to be improved. A number of respondents suggested additional services they thought needed to be developed to improve Pacific health. Suggested services included health promotion, maternal services, injury prevention, services for older people, mental health services, nutrition advice and sexual and reproductive services.

Many of the Pacific respondents addressed the great need for the development of Pacific services for Pacific peoples and a few were disappointed that this had not been specifically identified. One noted that existing Pacific staff tended to be found in the community health sector where they were poorly trained and received low rates of pay. They thought that these staff could be upskilled to meet the needs of Pacific peoples.

> *The absence of a clear direction to develop 'by Pacific for Pacific' providers is a notable omission. The Pacific health sector should be integral in the planning of services for Pacific peoples* (Hospital and Health Service).

There was also support for the idea that mainstream health care providers needed to be trained to deliver appropriate services for Pacific health service users. Several respondents noted that mainstream providers were often reliant on support from Pacific communities for effective delivery of services for Pacific health service users.

The difficulty of access for Pacific peoples was also mentioned. Causes for this included the lack of appropriate services, lack of knowledge of services available in the communities, lack of transport (particularly noted in Auckland), language barriers and the low socioeconomic status of many Pacific peoples.

It was noted that Pacific peoples were not an homogeneous group and that services needed to be aware that what might be appropriate with one Pacific nation might not be appropriate with another. It was important to note this fact when building the capacity of the Pacific workforce.

Other areas identified included:

?? a concern that existing Pacific health providers would be integrated into larger primary care organisations if these were required to have large population bases, thereby losing their autonomy
?? a need for more research on Pacific health needs and appropriate responses
?? the Ministry of Health should have a specific Pacific Directorate staffed by Pacific people to advise it on Pacific health needs
?? mainstream providers, eg, hospitals should have interpretation services
?? a concern that Pacific people would not be adequately represented on District Health Boards and a suggestion that these should include Pacific liaison services.

A few respondents were unconvinced about the need for a specific Pacific service priority. These responses did agree that Pacific health needs were high, but felt that this was also true of other low socioeconomic groups.

6.7 Other services suggested for prioritisation

Alternative services were identified which should be added to the list of short-to medium-term priorities. Those most frequently suggested were services for older people, children and youth, and complementary health care services. Special groups were held with refugees and Asians and with service providers for these groups. Other services were suggested in responses. These included:

?? personal health services in secondary and tertiary institutions
?? adequate rural health services
?? support services for people with physical disabilities
?? secondary services for people with mental health problems
?? rehabilitation and physiotherapy services
?? nutrition advice.

6.7.1 Services for older people

Fifteen responses suggested that services for older people should be included as a priority. A focus group was conducted with professional and voluntary providers of services for older people.

Some observed that services for older people should be a priority as this group was growing in size. The service needs of people also increased with age and there was likely to be an increased demand for disability services and secondary services as a result. It was suggested that there was a need for a strategy for older people which would lead to an improvement in the quality of these services.

In addition to the six priority services listed add the following: 'Efficient and appropriate access to Community and Hospital care for the elderly'. Inclusion of this priority would be:

1. *A further attempt to raise the status of elderly health care*
2. *A further incentive to Service Managers to curb further fragmentation of responses to meet the requirements of care for the elderly*
3. *A requirement that the health systems are understanding of and sensitive to the physical disability of the elderly* (Health care user).

It was noted that there were a number of reasons that older people often had greater need of services. Many older people:

?? had lower incomes as they were no longer part of the workforce
?? had physical disabilities and needed appropriate services such as physiotherapy and required support in order to remain living at home
?? had greater transport needs
?? needed specialised services such as dementia care (a service identified in one response as being 'not very sexy') and continence services.

6.7.2 Services for children and youth

Thirteen respondents identified child or youth services as a service that should be prioritised. These services were supported both because of the specific health needs of children and youth, and because of the role that played in New Zealand's future.

Specific barriers to the development of effective services for youth were identified by some. These included the cost of services, lack of culturally appropriate services for Pacific and Māori youth, transport and lack of information on appropriate services.

These service delivery services are important but it is important to recognise that existing models of health care will not result in health gains for the youth of New Zealand. Youth health needs to be prioritised and addressed through the development of specific youth health models (Health professional group).

A few respondents identified specific service needs for children. These included access to 'respite' care for children when families fall apart and strengthening additional services, for example, Plunketline which could reduce child abuse.

6.7.3 Complementary and traditional health services

Complementary and traditional health services were not covered in the discussion document. Many complementary health users and service providers commented on both the omission and the role that they felt that complementary health services could play in improving the health status of New Zealanders. Some of these responses stated that they would like to see complementary health care included as a principle or a priority area. Sixty-six responses were received on this subject.

Respondents described a number of complementary therapies in some detail, and the role that they could play on increasing health. Several suggested that these forms of treatment were holistic whereas most of the approaches endorsed in the discussion document were medically focused and based on the use of pharmaceuticals. The therapies described included:

?? Mäori and Pacific traditional healing
?? Ayuvedic medicine
?? rebirthing
?? homeopathy
?? reiki
?? Bowen technique
?? naturopathy
?? acupuncture
?? massage.

These therapies were seen to be able to address many health conditions, often more effectively than mainstream medicine. Conditions that they believed were effectively treated included smoking (cessation), allergies, childbirth, arthritis and mental health problems. A few suggested that natural therapies were also effective in health promotion and had a strong preventive focus.

Many stressed that they were not opposed to mainstream medicine, which they believed was effective at addressing many conditions, some of which they could not address. However they wished to see medical practitioners willing to work with traditional and complementary health services rather than ignoring them. Several traditional healers and complementary health providers noted that most (though not all) mainstream providers were unwilling to recognise the validity of their skills or to encourage people to use them.

Frequent reference was made to a recent survey conducted for the New Zealand Charter of Health Practitioners Inc. In this survey 35 percent of respondents said that they had used complementary therapies.

Many of the responses from complementary health care providers suggested that subsidies should be available for people who used complementary therapies. The reasons for this included that many people wished to use these therapies, but were unable to afford access to these without subsidies, and that these therapies were effective and often cost- effective.

7.   Implementation: Quality Services

The document outlined nine areas which contribute to high quality health care services. Each of these are highlighted and some ways that this would be ensured are described.

Many of the respondents addressed one or more of these qualities. Although the comments received are discussed under the separate headings used in the discussion document, many comments were applicable across a number of headings.

7.1   Individual rights

The first section described the fundamental rights that individuals have within a quality health system.   The document listed the ten rights that are covered in the Health and Disability Commissioner Act 1994.

Forty-six responses were received on this issue and all agreed that individuals should have rights within the system. Additional individual rights that should be included were suggested.

The most frequently suggested addition was the receipt of appropriate and accurate information related to a patient's condition. This right was related to informed consent, the right to full information on the alternatives available to the patient and the possible results or side effects of any treatment. One respondent pointed out, however, that this may be difficult to achieve with certain classes of patients, for example, comatose or mentally ill patients.

Several respondents mentioned the right to confidentiality of information. This was seen as particularly important for some groups such as youth. A few were concerned that individual information was being shared among providers without the patient's prior permission.

Further additional rights put forward for inclusion included:

?? a fundamental right to treatment
?? the right to have individual circumstances taken into account before discharge
?? the right for a woman to receive black and white photographs of her unborn child at every stage of pregnancy
?? the right to respect
?? the right to an interpreter when going to see a GP. (This point was made with particular reference to refugees and to new immigrants to the country.   One response noted that these groups are unlikely to be aware of the rights that they actually have)

?? the right to decline national health and disease prevention programmes such as immunisation
?? the right to decline to take treatment (for people with mental health conditions).

It was suggested that for rights to be effective people needed to know about them which implies more education with some groups. This included Asian people, refugees, pregnant women and youth.

Some respondents addressed the issue of actually upholding the individuals' rights. It was pointed out that effective monitoring procedures needed to be in place and that complaint procedures should be given priority and publicised. One respondent suggested that current procedures were often adversarial and this could discourage health service users from following a complaint through.

It was also pointed out that New Zealand is a signatory to the UN Convention on Human Rights and that Human Rights should be mentioned within the document.

7.2   Each part of the system must perform highly

Twenty-six submissions addressed this but there was common agreement that quality was important and that it needed to be monitored. However, some respondents addressed this when they were considering either nationally consistent quality criteria or principle 6.

The comments made included:

?? the need to recognise the role of complementary health providers as giving a high quality service
?? the need for providers to demonstrate that their services were clinically effective
?? that quality and quantity of services should be monitored in addition to outcomes which may take years to show.

We applaud the intention of better quality standards but stress the importance that this is translated into better patient care, not just process. We believe that this will only [happen] with clinicians providing patients with full and better information in a timely and appropriate manner (Health care provider).

7.3   Improved co-ordination

This section of the document emphasised the importance of work co-ordination both within the health sector and between the health sector and other sectors. It emphasised a move away from a competitive focus into a more collaborative

environment. Two-hundred and seven submissions commented in this area.[1] These came from service providers, community organisations, health service users and organisations such as territorial local authorities.

Most submissions agreed that greater co-ordination was vital for the sector and several welcomed the emphasis upon co-ordination and co-operation as opposed to competition. Several identified a key role for the New Zealand Health Strategy in promoting greater co-ordination. A few, however, noted that greater co-ordination should not be at the expense of the individual's right to confidentiality.

The Independent Practitioners Association of New Zealand identified a number of benefits arising from greater co-ordination of services including:

?? increased patient knowledge, attitude and self-management
?? decreased severity of disease or improved health status
?? improved treatment according to best practice guidelines
?? decreased use of emergency services and of non-emergency visits to doctors
?? decreased hospital readmissions
?? reduced mortality.

Some Mäori providers and co-funders were also enthusiastic about the benefits of co-ordination in improving the services and outcomes for Mäori. Several identified that many of the health problems for Mäori were because of several different determinants of health outside the direct sphere of the health sector. It was important that services needed to address all of these determinants.

Some organisations and health care providers reported that they were already active in improving co-ordination, both between providers and between providers and other groups such as patients, community agencies and territorial local authorities.

Examples included:

?? a territorial local authority described moves they were making towards developing services with public health services and iwi
?? home care services for older people involving primary and secondary services, support for older people and community groups (this project aims to reduce early admissions to rest homes)
?? the development of health programmes for schools by members of the Ministries of Health and Education
?? an organisation for the provision of services for mental health services involving housing, employment, health and social services and spiritual groups.

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[1] Unlike the other quality standards a question on this was included at the beginning of the document. It also tied in well with the emphasis on addressing the determinants of health and utilising a variety of agencies responding to the document and to many issues raised in the responses.

There were examples of areas that respondents felt needed increased co-ordination. These included:

?? between mental health services and drug and alcohol services
?? between 'orthodox' medical services and 'complementary' services
?? a closer association between the school syllabus and health care in areas such as nutrition and physical education
?? between caregivers, secondary care providers and needs assessment services
?? between Hospital and Health Services and Non-Governmental Organisations
?? between the public and private health sectors.

However, barriers to increased co-ordination were identified. Some respondents questioned how effectively or quickly this could be achieved in a system that had been based on competition for 10 years. One organisation commented that:

We cannot see how a health system which has worked in a competitive mode for many years can now change to a system which supports collaboration (tertiary institute).

Another possible barrier that was a lack of knowledge among providers of the benefits of co-ordination. There was concern that some organisations would see only the costs of improved co-ordination (examples given were more meetings, increased paperwork) whilst not truly appreciating the benefits to users of the service. It was pointed out that improved co-ordination may be more costly for the sector to achieve but was likely to result in improved outcomes.

A number of responses included a perceived tendency for providers to be competitive, to guard their patches and be reluctant to share information. A few thought this had been exacerbated by the commercial process.

The perceived right to autonomy and a strong element of patch protection are endemic in the health industry. This is exacerbated by the HFA contracting process which appears to authorise contracts which overlap and duplicate…It is hoped that DHBs will be better positioned to avoid such confusions (Group of community health providers).

Other barriers identified included:

?? a lack of appropriate information technology to share data
?? an unwillingness by many providers and health care users to share data
?? a lack of trust, respect and good faith between providers.

A number of ways to improve co-ordination were also suggested including:

?? more frequent consultation with specialist groups

- ?? the establishment of national bodies to facilitate co-ordination such as the establishment of a Rural Advisory Committee
- ?? greater utilisation of the assistance of territorial local authorities
- ?? District Health Boards actively working with other agencies such as local authorities, education, housing etc
- ?? 'one-stop shop' health facilities
- ?? an 0800 number to answer questions about health services across the country
- ?? service specifications explicitly emphasising co-ordination
- ?? a willingness by District Health Boards to co-operate with other agencies such as territorial local authorities, Government ministries and departments such as housing, employment, justice, education and non-governmental agencies
- ?? greater utilisation of pharmacists as the professionals that most people saw most often.

7.4 Overcoming the problems arising from isolation in rural areas

This section of the document acknowledged the special needs that rural areas have in relation to health services, and that extra support is required. A total of 43 submissions commented on this section. Many of these were from providers and users of services in rural areas and from organisations such as territorial local authorities based in rural areas.

There were three overriding concerns. The first of these was transport (or the lack of it) which was seen as a major problem for people living in rural areas. Respondents noted the additional costs of transport faced both by individuals in getting to facilities and by providers who have to send patients long distances to particular facilities. Distance and the quality of roads were also noted as problems.

Equity issues were also raised. Concern was expressed about the ability District Health Boards would have to ensure equity of access for individuals living in remote areas.

Workforce recruitment and retention was also a major concern. There was concern about the difficulty in attracting providers to rural regions, in ensuring 24-hour services, and in retaining rural health facilities such as rural hospitals.

Home-based services, oral health services and emergency services were also identified as problems in rural areas. A need was identified for strategies to attract and retain suitably qualified individuals to work in rural areas. A few were hopeful that the Health Workforce Advisory Committee would play a useful role in this process in future.

Some of the suggested ways in which health care for rural communities could be improved included:

?? greater emphasis on intersectoral collaborative work envisaged by the Strategy would be effective but it may be difficult to achieve improvement in some areas where rural trusts were already demonstrating the values of co-ordination

?? setting appointments later in the day for individuals who had to travel long distances

?? an increased role for nurse practitioners

?? ring-fencing the funding for provision of rural health services when these become the responsibility of District Health Boards

?? education of families in remote areas in basic medical knowledge

?? support for volunteer ambulance staff

?? the provision of a transport subsidy

?? increased use of outreach services, one stop shops and the strengthening of innovative services such as Plunketline and Healthline

?? development of a rural health strategy

?? adding rural health as a priority area in the Strategy

?? guaranteed equitable representation on District Health Boards for rural people.

One local authority commenting on the centralisation of health services commented that:

they can be quite inappropriate to users due to the high time and travel costs involved both to the patients and their supporting families. The increasing trend of requiring that rural patients and their supporting families must travel long distances to receive even relatively minor health services promotes fear and isolation in rural communities and provides resistance to correctly accessing health services, medical complications, delays in recuperation, and drives in extra costs for families at a time when they can least afford it. (Territorial local authority)

7.5   A high-performing health sector to improve outcomes for Maori

Comments on this section have been incorporated into Section 6.6.

7.6   Information management and technology

This section of the document emphasised the importance of timely and relevant information both for health care professionals and for communities and individuals using health care services. It pointed out that a New Zealand Health Knowledge Strategy is being developed to support the New Zealand Health Strategy. Thirty-nine responses commented on this issue.

Most agreed that such information was important, particularly if the goals and objectives outlined in the Strategy were to be achieved. None disagreed with the importance of collecting information. However, a few emphasised that

information had to be collected for a purpose and that this purpose should be clearly defined to prevent the 'gratuitous' collection of data.

We would like to see an emphasis upon the use of information and not just its collection (health professional organisation).

Some noted that other areas addressed in the Strategy, such as intersectoral collaboration also needed accurate information to turn them into a reality. A number emphasised the importance of information in the more general monitoring and auditing of District Health Boards performance and to establish the ability to benchmark District Health Boards. More specific comments were made and these included:

?? issues around the high cost of setting up information systems
?? issues around ensuring national consistency in both data definitions and also in systems
?? the need to improve ethnicity data
?? the need to have appropriate, accessible information on medicines for safety reasons
?? a recognition of the potential for e-health strategies
?? the need for a national database of services for older people
?? the need for a national database for children (this was felt to be important with mobile families)
?? in terms of the provision of data, the possibility of a central data 'source' for the sector to access
?? the importance of maintaining confidentiality for health service users.

7.7   Workforce issues

The discussion document recognised that in the future there may be a requirement for different workforce skills to those needed at present. The Health Workforce Advisory Committee (HWAC) mentioned in the document has now been set up to provide advice to the Minister of Health on the development of the health workforce. The committee was supported in a number of responses.

One hundred and sixteen submissions addressed workforce issues. Three general themes emerged from these responses relating to shortages of staff, recruitment and retention.

Shortages of staff: This was a major issue for many from both health care users and from providers. For some, a particular cause was the perceived increase in the numbers of doctors and nurses moving to Australia because of higher salaries or to avoid student debt.

This shortage of staff resulted in:

?? a reduction in the morale of health care providers

?? the use of inappropriately qualified people in primary health care and some secondary institutions

?? health care providers finding it easier to prescribe pills than having the time to discuss issues fully with patients

?? low staffing levels and safety implications

?? an increasing stress on voluntary service providers with inadequate recognition or funding of these services.

Recruitment respondents highlighted problems in recruiting appropriately qualified people to the workforce. This issue cut across a number of areas including recruiting to rural areas; and to particular specialities, services for youth, health promotion experts, Maori and Pacific providers and other ethnic groups. In this context the difficulty that doctors were having in becoming registered in New Zealand was mentioned.

The New Zealand Medical Association noted that there were workforce shortages for doctors, nurses and technicians. A particular concern was that:

> *There is evidence that fewer graduates are attracted to General Practice overall, and anecdotal evidence suggests that graduates are more likely to go overseas and less likely to return to NZ because of problems of debt and remuneration.*

Retention: The issues of retention of trained staff was also highlighted. A number of submissions highlighted perceived trends that people were training in New Zealand but then going overseas.

In addition to the above there were some consistent messages from more specific groups. There were meetings with Maori and Pacific peoples, and written responses from Maori providers and co-funders and Pacific providers which addressed workforce. Many of these observed the need for a greater emphasis on developing the workforce of these groups. It was also pointed out that more staff from other ethnic minority groups are also needed.

Some of the issues facing these groups are the same as the general points above, but the workforce is much smaller which increases problems.

> *We find it hard enough attracting good, highly qualified Maori staff — It's even harder retaining them* (Maori provider).

Other issues affecting the availability of Maori and Pacific providers included:

?? less money available for Maori and Pacific providers as that for tau iwi providers. These providers were therefore unable to offer competitive rates of pay

?? these organisations often did not have the funds available to establish new services. They would therefore require 'hump funding'

?? there were many people with some expertise at delivering health services among **Maori** and Pacific peoples. Their skills could be increased more cheaply than training people without any expertise.

The needs of youth were highlighted as an area requiring specific skills and workers. This would mean additional training for providers and an increase in the number of people appropriately qualified to work with this group.

A number of other issues were also raised. These included:

?? in order to achieve the population health objectives of the Strategy more public health and health promotion nurses would be required
?? greater use could be made of complementary health providers if adequate funding were available to support their utilisation
?? greater potential for use of new technology approaches such as Healthline, Plunketline and the Internet
?? while there were growing numbers of female GPs there were still low numbers of specialists. This was an issue for women who preferred to be treated by women.

7.8 Action on goals and objectives: national consistency and local flexibility

This section of the document discussed the necessity to have central direction of policy while at the same time retaining local flexibility to enable District Health Boards to make decisions in accord with local circumstances. Forty seven responses addressed this topic.

Of those that did comment, many saw potential problems in achieving this standard. Many of these made the point that national consistency was needed to achieve a high performing system. They were concerned that local autonomy was not at the expense of national consistency. A few asked how local flexibility would fit with national health goals as proposed in the discussion document.

Some respondents commented that national consistency was crucial for a variety of areas including quality and equity. The cervical cancer screening programme in Tairawhiti was mentioned in this context. Another remarked that small hospitals were not safe places for surgery and was concerned that District Health Boards would encourage these.

We see the local versus national control bodies and the maintenance of national standards as being the conundrum of this document (Community-based support organisation).

Suggestions for ways to avoid these problems were made including:

?? a need for the Government to decide and define what services needed national consistency and which could be more flexible
?? the provision of a central body, such as the Public Health Commission or similar body to co-ordinate on nationally important issues
?? the establishment of community co-ordinators who might be attached to Public Health or Disability Resource Centres to oversee services
?? the requirement that goals and objectives were tackled with evidence-based strategies, not individual District Health Board-based strategies
?? the development of clear treatment protocols and standardised monitoring processes to be carried out nationally.

While there was considerably less overt support for local flexibility it was not without its supporters. One response suggested that the presence of elected members on the boards would provide a strong incentive to respond to the needs of the local community. However, they supported the idea that the boards would be rigorously monitored by the Ministry of Health. A national advocacy group thought that flexibility would be needed to move from a focus on body illnesses, as they believed had happened during the previous nine years.

7.9   Mechanisms for achieving a high-performing system

This section of the document looked at ways in which a high-performing system could be ensured and highlighted four areas:

?? regulatory requirements
?? funding agreements between District Health Boards and the Government, and District Health Boards and local providers
?? professionalism
?? a learning culture conducive to continual quality improvement.

Eighty-four responses were received on this section and there was strong support for the concept from almost all these responses.

Although the comments made were wide ranging, a few consistent themes came across. One was the need for ongoing evaluation and monitoring of service providers to ensure that quality, performance and safety were all being maintained. One submission commenting upon this stated that:

There must be more included in this document on how the Government and Ministry of Health propose to audit, monitor and evaluate the health sector to ensure that health services are delivered to individuals and local communities that meet appropriate standards of care, that meet the needs of people as well as adhering to the principles, aims and objectives contained in the New Zealand Health Strategy (Advocacy group).

There was some discussion on how performance should be monitored and evaluated. The need for open and transparent processes was emphasised, and the question of who should actually do the monitoring was raised. Some respondents suggested that a new organisation should be set up to perform this role. One submission suggested a health equivalent of the Education Review Office should be formed.

A few respondents linked the need for monitoring and evaluations to priorities in health care. Some responses preferred that the assessment of success should not be based on funding agreements but the delivery of health outcomes:

> *(There must be) mechanisms for ensuring that those (DHBs) not making progress have to develop plans for reaching them and that there is accountability to a central agency (such as the Ministry). This should not be framed in the context of 'funding agreements' but within the context of improved population health status and service delivery.*

Another key theme was the need for effective complaint procedures, which was seen as critical for a high-performing system. These responses argued that effective complaints procedures are vital to ensure accountability and to give the public continued confidence in the service. It was important that complaint procedures were made appropriate for all ethnic groups. Allied to this was the suggestion that any evaluation and monitoring processes introduced should have the results available to the wider public. A number of respondents mentioned benchmarking in this regard.

Several respondents argued that professionalism, the working relationships between professionals and the development of a learning culture are the keys to ensuring a high-performing system. Leadership from professionals and managers was seen as important for these to develop.

A number of other issues were raised in submissions on this area, including the importance of:

?? developing and maintaining good working relationships between the Ministry of Health, District Health Boards, iwi and local government
?? a transparent and evidence-based system of prioritisation
?? continuous quality improvement
?? evidence-based practice, with clinical governance being encouraged
?? national consistency
?? appropriate information systems to collect required information on service utilisation, quality etc
?? continuing education programmes for all health care workers.

7.10   Nationally consistent quality criteria

The provision of nationally consistent criteria was not discussed as a separate section within the document but was mentioned in relationship to other areas. A number of respondents referred to the lack of a list of such criteria within the document.

A large number of respondents referred to the importance of nationally consistent criteria. Some referred to the list on page 23 of the document and the discussion on quality. Many argued that national consistency was vital to ensure equity across the country. Some noted that any criteria should be culturally appropriate and ethical. A small number of people felt that separate criteria were needed for children and adults.

8   Consultation

The document asked three questions about consultation. People were asked to comment on:

?? effective ways for people or their communities to be consulted by the Ministry of Health or District Health Boards
?? the best ways for people to be informed in order to make informed comment
?? issues they thought the District Health Boards and the Ministry of Health should consult them on.

Almost all responses agreed that it was important that District Health Boards and the Ministry of Health consulted people and communities. Many said that there were strongly in favour of consultation and some noted that they or their organisation were willing to be consulted on any relevant issues in the future.

8.1   Ways to consult people

Public meetings to discuss documents such as the Strategy were endorsed in many responses.   These meetings might vary from relatively short public meetings to longer meetings with invited audiences who had expertise in the areas being covered.   Several responses observed that it was important that District Health Boards set up consultation processes as soon as possible after they are established.

A number of respondents noted that for consultation to be effective there should be better communication of when the consultation process begins and ends, effective notification of where public meetings are being held, television and radio notification, and wide distribution of any consultation document through many different agencies.

> *Community Health Groups offer the best vehicle for consultation being as they generally include both consumers and health professionals. They have a long history dating back to 1986 and should be revitalized to meet the needs of the community of an agency for consultation with District Health Boards future.*

Several respondents thought that public meetings were not always the best way to ensure participation from some groups. Those groups mentioned included **Maori**, Pacific peoples, people in rural areas, young people and people with disabilities. For these people alternative methods of meetings were suggested including hui and fono and small group meetings. Some suggested 'piggy backing' on existing meetings might have value. A number of respondents offered to provide assistance at reaching these groups if necessary.

Not everyone was enthusiastic about public meetings. One response noted that meetings about health issues tended to attract the same types of people. These were paid providers and those from the unpaid consumer voluntary sector. A few suggested that these groups were beginning to feel 'burnt out' and one organisation said simply 'No more meetings please'.

There was also strong support of the process of making written submissions to documents. Again some of the important issues raised about meetings were seen as important such as the length of time of the consultation and the advertisement and distribution of the document.

Some respondents also suggested other methods of consultation that they thought could be useful in some areas. These were not seen as alternatives to meetings and written submissions but in addition to them. Methods suggested included:

?? the establishment of local committees of consumers and providers, perhaps supported by the District Health Boards, to discuss developments and proposals and advise the District Health Boards of their preferences. These might meet regularly with the boards.
?? the establishment of community liaison positions. These people would be responsible for liaising with a wide range of community and provider representatives. Such positions were suggested for rural areas and areas with large numbers of Pacific people.
?? regular communication and meeting with health care providers, such as reference committees. Groups suggested included general practice teams, rural health trusts and specialist provider networks. Several responses noted that it was important that providers have regular and ensured ways of communication with District Health Boards.
?? the use of other methods of communication for distributing information and seeking input, such as posters, emails and the Internet
?? written and telephone surveys.

A few people stated that electing District Health Board members would be an effective mechanism for ensuring District Health Boards were accountable.

Several people made comments on the process of consultation, and the importance of it being a two-way process, where the Ministry and other bodies were willing to listen and to make necessary changes where this was supported.

There was also some comment on the timing of meetings (and other forms of consultation). These responses felt that they were often finally consulted when all the decisions were already made and input from the community would have little chance of making a change. Some people also argued that the consultation process would be hindered if organisations/individuals writing submissions and attending meetings were not able to see their input influencing the resulting health policy.

Other issues raised included:

- ?? the value in co-ordination with territorial local authorities, many of which had considerable experience with consultation
- ?? the length of time for submissions did not always lend itself to those groups that needed to consult widely with their community or membership (particularly noted by Mäori groups)
- ?? the importance of ensuring that adequate time is allowed after meetings for written submissions to be prepared
- ?? the establishment of groups of experts who could be consulted on specific issues when they arose
- ?? the importance of appropriate interpreters at meetings for Mäori, Pacific people, deaf people and provision of information in Braille
- ?? a free flow of information from District Health Boards to their public could obviate the need for consultation other than on major issues
- ?? the value of establishing a timetable for consultations ahead of time (by the District Health Boards) so that people could plan to attend ones of interest to them.

A very small number of respondents mentioned that consultation needs to be limited and the money saved for services while a few people favoured the return of the Community Health Groups.

8.2   Effective ways to distribute information

People were asked to nominate ways that they thought were effective for the distribution of information.   Approximately a quarter of responses made suggestions about a range of methods needed to be used to ensure that everyone received the information.   A wide range of familiar methods of communication were suggested. These included:

- ?? distribution of regular public reports on the performance of District Health Boards
- ?? regular slots in newspapers, particularly community newspapers and other widely read magazines and health provider journals
- ?? community meetings and the use of community groups to disperse information
- ?? posters distributed by mail and put up in places that people could see them, such as libraries and council offices
- ?? the use of sound media such as television and radio, usually for more important issues
- ?? newsletters and leaflets giving information about current issues in the health sector, and upcoming consultations
- ?? other electronic communication methods, such as *Health Moves* and other existing electronic newsletters and the Internet, were also endorsed by some, although others thought that reliance on these would prevent many people from accessing the information
- ?? discussion documents like the one published for consulting on the New Zealand Health Strategy

?? the importance of providing information in **Maori** and Pacific languages was stressed by some groups.

8.3   Issues on which it is important the public are consulted

A quarter of responses addressed the issues for consultation. Many of these responses addressed issues of particular interest to the people making the submissions rather than an approach to the overall concept of consultation. Issues suggested included diabetes, the availability of elective surgery, mental health, services for specific groups such as youth, older people or **Maori** and Pacific peoples. A few suggested that all health issues were important enough for consultation.

Other subjects suggested for consultation included:

?? the relationship of District Health Boards and non governmental organisations in the delivery of services
?? the level of care provided by the public health service
?? new health initiatives
?? the strategic objectives, service priorities, funding and evaluation of services
?? monitoring
?? the role of complementary health providers
?? the delivery of services in rural areas
?? **Maori** health services
?? Pacific peoples' health.

Some respondents thought that it was not always important to consult with the general public where specific issues were being addressed or the issue was of interest only to specific geographical areas. For these issues it might be more appropriate (and practical) that consultation was with providers and consumers who would be affected by any suggestions. Sector reference groups were also endorsed for this type of consultation.

Some people thought that it was important that District Health Boards consult when they make changes to existing levels of service provision or deciding on priorities for service delivery, as the Health Funding Authority currently does. These issues might be either alterations in service type such as the addition or removal of services, changes in the types of providers or quality levels.

There were a few suggestions that the Ministry (rather than the District Health Boards) needed to consult when they were making high-level decisions about future policies or the amount of money that was available for District Health Boards or specific services.

9   Mäori perspective on the document

9.1   Introduction

This section of the document looks at all responses received from Maori. Eight hui were held to ensure that the Maori responses to the document were heard. There were 29 written submissions from health care users, Mäori providers and funders,. While many concentrated on issues of particular relevance to Maori, others addressed many of the sections.

In common with the rest of the report most comments received were favourable.

There was some comment on the Treaty of Waitangi, its incorporation in the document and the ways how the NZHS could be used as a vehicle for Government to meet its Treaty obligations

A number of comments on the proposed changes to the health sector were also received. Some of these responses thought that the changes would inhibit further Mäori development. Some made suggestions about how to build on the gains already achieved.

9.2   Overview of the NZHS

Few respondents commented on the total NZHS itself, with many preferring to comment on particular chapters and sections within the document. Those that did do so (mostly Mäori providers) believed that the NZHS did not adequately reflect Mäori health values or Mäori models of health. One Mäori provider thought that the NZHS needed to be realigned to maintain the integrity of Treaty of Waitangi provisions and principles.

NZHS is weak in framing systems and processes to demonstrate how the sector will be held to account under the Treaty of Waitangi (Mäori health provider).

Some believed that the document lacked sufficient detail or specificity on how the goals and objectives for improving Mäori health would be delivered, and how the system would be held to account for its performance on this matter. This paucity of information concerning the next steps, timeframes and responsibilities was a cause of concern for many.

The NZHS is promoted as a living document but doesn't provide any clarity around the practical application or implementation of high level objectives. (Mäori co-funder).

9.3 Fundamental principles

Fifteen responses addressed the seven principles. There was support for the use of principles to guide the sector's development. A HHS considered that it would have been more profitable to use a mission statement as opposed to a set of principles. Despite the positive feedback, some considered that the principles would have been more useful if performance targets, or more information as to how they were to be accomplished, were provided.

> *The establishment of principles is supported. However, the implementation of policies to fulfil those principles is crucial* (Mäori health provider).

A number thought the relationship between the goals and objectives was also unclear, as was the link between the NZHS and other sector strategies, particularly the Mäori Health Strategy.

Some respondents also felt that the document needed to better reflect the Treaty of Waitangi principles, both in terms of the NZHS being principle driven, and its prominence throughout the document.

9.3.1 Changes to the principles

Many suggested additions and/or a re-ordering of the principles. Some indicated that Principle 5, which dealt with the special relationship between Mäori and the Crown, should be ranked higher, or even the highest. However, such re-ranking was not limited to Principle 5. The importance of Principle 3, greater collaboration, was frequently cited.

> *We believe this is to be a decent aim as it may bring about desperately needed improvement, in co-ordination and collaboration between various areas of the sector thereby encouraging co-operation and improved relationships all along the health/welfare chain.* (Mäori health provider).

Some responses considered additional principles were required. One Mäori co-funder provided additional principles. These additions related to the explicitly recognising the Treaty principles. Meanwhile, participants at a hui considered that the Principle 5 simply needed to be strengthened.

> *The Treaty of Waitangi in the NZHS shows mature thought by this Government and its willingness to do what it can to alleviate the disproportionate suffering among Mäori. Howe ver, the Treaty must be given sharper teeth if it is to appropriately support Mäori development and advancement.* (Mäori health provider).

9.4 Goals and objectives

There was little comment on the overall goals and objectives and much of the comment received concentrated on specific goals and objectives. Community development and empowerment, increased choice for Mäori and improved access were concepts that were endorsed by providers and co-funders. However a few queries about the value of the concept of the goals and objectives were raised. These included:

?? how useful were goals and objectives if there were no performance measures to ensure accountability
?? there appeared to be little research to justify their inclusion.

Some respondents also commented on the need for additional goals and objectives, particularly in terms of making Mäori issues more explicit. One Mäori co-funder suggested that goals based on equity, partnership, and economic and social security were needed. Another suggested that disability goals and objectives also needed to be included.

Most suggested alterations centred on individual goals and objectives. Goal 9: Mäori Health Development and its accompanying set of objectives were singled out. Respondents who commented on Goal 9 and objectives 46-50 stressed the Treaty's importance, as well as the need to build on current HFA initiatives.

> *The principles for the development of goals and objectives that will affect improved health and reduced disparities should be based on the special status that Mäori have as tangata whenua* (Mäori co-funder).

One co-funder also questioned why the HFA's eight Mäori health gain priority areas and three key strategies were absent from the list provided. One Mäori provider considered that Mäori co-purchasing was an important component of Mäori health development. One hui suggested that all the goals be reworded as they focused on don'ts rather than do's.

9.5 Priority objectives

The need for more specific targets and health gain measurement tools to determine progress towards the achievement of priority areas was highlighted by some respondents. There was also some concern that no rationale or criteria was provided to explain how the priority areas were chosen.

> *Criteria used to prioritise the health areas is unclear. Difficult to assess which specific health areas are a priority and what, for example, funding implications would be* (Mäori health provider).

Comment relating to specific priority areas was mostly concentrated on the first priority objective. With the exception of one individual, there was broad agreement to reducing disparities as a priority area. However, some respondents objected to Mäori and Pacific peoples being lumped together, with one justifying a separation based on the Treaty relationship being between Mäori and the Crown. Once again, it was considered necessary to develop measures to demonstrate whether the disparities were being reduced.

Few respondents indicated if they agreed with the remaining priority areas chosen, although additional priority objectives focusing on rangatahi health and sexual and reproductive health were proposed.

9.6   Service priorities

Few respondents addressed the service priorities other than Mäori advancement in health and to a lesser extent mental health. Those who did respond to other areas agreed with their inclusion.

One provider said that the focus on Mäori was important given the significant disparities that existed. One hui also highlighted the importance of traditional Mäori healing practices, and that greater Government recognition was required, particularly in terms of funding.

9.6.1   Improving the responsiveness of mental health services

The comments on mental health revolved around what services fall under the auspices of mental health, where mental health services are best delivered and what constitutes quality mental health care.

> *Mental health patients require consistent attention/follow-up and in some cases there are minimal professionals to follow-up on progress and treatment or a PET team that is two hours away.* (Territorial Local Authority).

9.6.2   Maori advancement in health

There was widespread agreement with this priority. Comments on Mäori advancement in health canvassed a range of issues. Some health care users, co-funders and providers referred to Closing the Gaps. A few noted that Closing the Gap itself would require establishing what the gap was which was dependent on the methods used to measure the gap.

Increased funding and accountability were other significant factors for Mäori advancement. A co-funder also considered that local solutions to local problems was an important mechanism, as was mainstream providers reorienting their services to improve Mäori health outcomes suggested by one health provider.

There were a range of issues which many, particularly Mäori health providers, considered needed to be addressed. The lack of clearly specified objectives and the need for greater prescription in the document with regard to Mäori was reiterated. Funding was another important issue. Respondents thought that the level of funding provided should be related to measures of deprivation, and should be more than just that required to achieve equity.

A Mäori co-funder considered that any consultation which was to take place with Mäori should be facilitated through iwi organisations. However a provider questioned the usefulness of existing HFA Treaty relationships and considered that they should be reviewed. The mandate of Mäori development organisations was also called into question.

Most comments tended to focus on the ineffectiveness of current systems and process to improve Mäori health. By building on present structures, many respondents felt that the NZHS was not doing justice to Mäori health problems because Mäori are being treated in a similar manner to other peoples, when this was not the approach required.

They thought that what is required is a new approach based on Mäori control and a Mäori health strategy, not the ethnocentric approach epitomised in the NZHS. This approach would help to protect Mäori intellectual capital, which it was felt was being used inappropriately by the Ministry of Health. A related issue was the need to support Mäori providers and to define the role of Mäori development organisations in the new structures.

To a certain extent, these comments echo those made earlier concerning the NZHS's lack of innovation (or more precisely, a Mäori way of approaching problems), and doubts as to whether Mäori health would be protected and maintained. Other important areas that needed addressing were Mäori smoking cessation programmes delivered by Mäori, and Mäori alcohol and drug services.

9.7   Implementation: quality services

There was general agreement on the need for service criteria. Responses tended to focus on particular criteria. However, there was some confusion as to what criteria were being commented on.

What are these key criteria? Where do I find them? (Health service user).

Four criteria that were singled out were improved co-ordination, rural issues improving outcomes for Mäori health, and workforce issues.

9.7.1 Improved co-ordination

There was agreement across the spectrum of responses for better co-ordination of care. Responses thought that both inter- and intra-sector co-ordination would allow better access to health services, more responsive delivery modes, improved service quality and better Mäori health outcomes.

> *Agree that better co-ordination for health services directed by structural incentives is essential to improving Maori health gain* (Mäori health provider).

It was also felt that the NZHS needed to show leadership in this area with a view to ensuring inter-sectoral commitment to greater collaboration, and to build on existing initiatives and structures.

9.7.2 Access to rural health services

Rural access to services was an important service issue for one provider. It was stated that services for urban areas had a higher priority than those situated in rural areas. They thought that needs of rural communities were not going to be satisfactorily met as the new structures were unlikely to deliver the necessary services to meet the particular needs of rural communities or their health providers.

9.7.3 A high performing health sector to improve outcomes for Maori

Only a few respondents explicitly agreed with the need for an effective health sector which improves Mäori outcomes. A number provided suggestions about how this service could be achieved. These included:

?? reallocation of funding for workforce development for training and staff retention
?? research into improving Mäori health was a key element, and should be led by the Ministry
?? development of comprehensive approach to quality care to improve Mäori health. This would require recognition of the particular health needs of **Maori**, and appropriate services to ensure that they were met. It would also require kaupapa Mäori orientation for health professionals, increased Mäori provider development, provider collaboration and communication, and quality accreditation of health providers
?? development of regional initiatives for providers to collaborate and communicate.

Increased accountability for Mäori health outcomes was thought to be an important lever for ensuring District Health Boards responded to these goals. Treaty obligations were also considered to be important in this regard. Relationships with Mäori were also considered to be crucial if the sector was to respond positively to Mäori health problems.

> MDOs should have the operational relationship with the District Health Boards (the governance relationship is with whänau/hapü/Mäori) (Hui).

Essentially, a system that wraps around Mäori values, frameworks and patterns of use was considered to be the best way to improve sector performance.

9.7.4 Workforce issues

Many respondents felt strongly about the need for workforce development, with many agreeing that further work needs to be done in this area. Many considered that this was a priority if their were to be gains in Mäori health, and if Mäori providers were to be sustained and developed in the future. Some respondents felt that certain professions were already at risk, and called for greater levels of funding to be provided for the recruitment and retention of health professionals.

It was also thought that more funding would alleviate the problems of burn-out and underpaid staff. Workforce development should not be limited to traditional health professions such as nursing and doctors. Training for other professions more relevant for improving Mäori health were also required, and should occur in appropriate institutions.

Concerns were also raised about the competency of District Health Board board members. This highlighted a wider concern Mäori respondents had about the need for non-Mäori to be conversant in Mäori issues if Mäori health outcomes were to improve.

9.7.5 Other quality issues

Of the remaining criteria, the need for greater prominence to be given to rural health needs was highlighted, as was the need for more funding for rural services. Improved ethnicity data collection, IT links for rural services, and the use of centralised systems to disseminate information were also important issues raised in the context of information management and technology. National performance indicators were also important, as was the need to identify how the Treaty of Waitangi was to be incorporated into accountability agreements. Consistent levels of quality as well as additional District Health Board committees would also improve the sector's performance.

9.8   Consultation

Only a few responses commented directly upon the next stages of the Strategy's development. Those that did said that the best way to keep the public and Mäori informed was through public meetings, local body elections and providing opportunities for face-to-face interaction with both decision makers and managers.

Some respondents commented on the need for Mäori input into decisions, and that this input needed to occur at all levels of the health sector. Hui were considered by some to be the most appropriate means through which to get Mäori input on issues, although sufficient time and information should be allowed to ensure quality advice could be offered.

Another suggestion for seeking public input was the use of emails or a website. However, another response warned against the exclusive use of these mechanisms to garner responses. Only two responses, both from health service users, commented on what issues the public needed to be consulted on. One provided a specific list, whilst the other thought the decision was best left to those actually making the decisions.

9.9   New structures

A significant number of responses were received on the new structures. There was some support for the sector changes. The new structures were perceived to allow local input into decision making, a more co-operative, rather than competitive environment based on collaboration, and would allow for more effective Mäori representation. For these reasons, it was expected that there would be a greater focus on wider health issues as opposed to just HHS service issues. However some thought that 50/50 Mäori representation on District Health Board boards was required if District Health Boards were to be effective in meeting Mäori health needs.

50:50 Mäori representation on the boards. Only then will disparities be addressed and the system will work for Mäori (Hui).

Despite the positive feedback on the new structures, some Mäori within the sector were disturbed by the changes. The greatest concern was that Mäori, both providers and consumers, would be marginalised by District Health Boards. It was also felt that rural communities were particularly at risk.

There is no guarantee that the proposed health structural changes will recognise and give effect to the health needs of rural communities (Mäori health provider).

The reason for the concern was based on past and present experiences. Given the poor record of HHSs in responding to Mäori health needs, building District Health Boards from HHSs was thought to be unlikely to provide the necessary focus on Mäori interests. These concerns were heightened by HHSs having sole responsibility for the transition of HHSs to District Health Boards.

It was also felt that the ability of DHBs to both purchase and provide services would create a conflict of interest, posing a number of risks to Mäori providers, Mäori health, and Mäori health development in general. Some responses also commented on the similarities between District Health Boards and Area Health Boards, and the memories of hospital domination in the provision of services.

A number of responses commented on the uncertainty which existed as a result of the changes. Some hui participants and providers were unsure of the status of existing contracts in the new environment. Some considered that it was necessary for the Minister to front up to Mäori to explain what was going on.

Some felt there needed to be a clear policy on Mäori representation on District Health Boards, as well as similar requirements for Mäori participation on transitional boards. Another concern raised was the inability of electoral processes to result in any, let alone equitable, Mäori representation. These processes were considered unfair, and it was thought appropriate to implement Mäori processes to elect Mäori District Health Board representatives.

One respondent also felt that there was little alignment between the NZHS and the sector changes. The regional nature of District Health Boards would result in the poor co-ordination of services, no collation of information and little community representation at the national level. The use of a Treaty-based national health network was proposed to rectify this problem. It was felt that the network would provide better co-ordination of Mäori information and interests. Another suggestion for improvements in the sector was for the establishment of a complaints process if Mäori considered District Health Boards were not fulfilling their Mäori health responsibilities.

A major area of contention was District Health Board partnership with Mäori. Many felt that the Government was defining what constituted partnership, although it was recognised that community engagement was important to ensure a sense of ownership. Whilst some agreed with mana whenua as the partners, others questioned the validity of mana whenua because of its exclusivity, instead suggesting the relationship was with iwi/hapü or Mäori.

Some thought that it would be unfair and resource intensive for Mäori to sustain relationships with a number of District Health Boards. Conversely, where many

iwi occupy a single District Health Board region, conflict may arise if different iwi held different views. Therefore, it was considered necessary by one provider that Mäori processes be used to sort out how relationships with District Health Boards should be developed, and that iwi sort it out for themselves. It was also felt that these new relationships should not be at the expense of current relationships.

If such relationships were to develop successfully, they would need to permeate the entire District Health Board. This would require not only training for District Health Board board members and managers on Mäori issues, but also recognition of Mäori ways/approaches to doing things. In this way, co-operation between Mäori and non-Mäori organisations would be enhanced, and Mäori control of health resources to meet Mäori health needs could be promoted.

> *Ensure that DHBs have strong and mutually beneficial relationships with whänau/hapü/Mäori, providers and the MDO* (Mäori health provider).

One question raised was who would sort out problems between District Health Boards and Treaty partners, and who would be the appropriate referee in such as event.

This was part of a wider issue concerning Mäori input into District Health Board operations. Many commented on the need for the District Health Board to be accountable to Mäori. One suggestion for operationalising this was by local Mäori having sign-off of District Health Board plans. Others stressed the need for Mäori input in decision-making processes, including in the development and implementation of needs analysis.

Further, operational relationships should be flexible enough to accommodate Mäori providers as well as MDOs and MAPOs. It was generally felt that strong relationships with Mäori at all levels was important.

As expected, funding and contracting were important issues for many. Direct resourcing of Mäori or Mäori control over funding was seen as important to allow Mäori to meet their own health needs. However, it was realised that there was also a need to protect the funding for Mäori health services. A ring fence seemed the most popular means through which to do this. Nevertheless, many recognised the disadvantages of ring fencing, citing that it imposed a ceiling on the level of funding available, and that it tended to stifle innovation and collaboration.

Additional funding was also required for smaller providers. The scale and scope of their operations limited their ability to manage financial risks and to develop their operations further. One provider also considered that the development of smaller providers had been overlooked in the drive to consolidate other Mäori health organisations.

One provider said that services currently held by District Health Boards which could be provided by other providers should be shifted out of District Health Boards. Doing so would allow for a reallocation of funding to areas where it could be used better. Others held similar sentiments with regard to the reallocation of funding. It was felt that funding should be shifted to important areas for improving Mäori health such as primary and preventative health. Mäori provider development and workforce development were other priority areas for funding. One group also suggested that resourcing be made available for the development of a iwi audit organisation, similar to CCMAU, to monitor the performance of District Health Boards.

Contract design was another area which drew much comment. Short-term contracts provided little certainty for providers, and current contracting systems imposed high compliance costs on Mäori providers. Pricing was another important issue, as current levels were insufficient to cover the costs faced by many Mäori providers.

> *The value of contract does not reflect the need of the service. These are run on the smell of an oily rag* (Hui).

Many recognised the need for funding to be allocated on the basis of health needs. However, the population based funding formula (PBFF) was not considered to be the most effective means of doing this for Mäori, as the statistics used in PBFF calculations did not reflect actual need. Participants at one hui suggested that Mäori should receive 50 percent of Vote Health.

A number of other issues on the new structures were raised by Mäori submissions. Mainstream enhancement was an important element to the success of the new environment in meeting Mäori health needs. One provider considered that mainstream enhancement should be funded from baselines as opposed to allocating additional resources to this task. Better **Maori** health data was another area requiring attention, as was the need for suitable accountability and performance measures. It was also felt that District Health Boards needed transparent processes in place, particularly given the 'cloak and dagger' approach taken to the appointment of members on Transitional HHS boards. The need to retain Mäori within the sector was also important, as well as the need to upskill Mäori communities so that they can more fully participate on District Health Board boards. Mäori input was also considered crucial in the development of the Mäori Health Strategy. Finally, suggestions for additional District Health Board committees were provided, as was the need for new approaches to be taken to improving Mäori health.

Appendix 1

Several small groups were organised to consult with groups who might not otherwise make a response to the document. These were refugees and Asian people. Groups were also held with providers of health care services for these people.

Services for refugees and asylum seekers

A few written responses identified a need for the inclusion of specific services for refugees and asylum seekers. A specially organised group was held with representatives from the refugee community and with another with providers of health and social services for refugees.

These groups identified a number of reasons for developing specialised services to respond to the needs of refugees. While refugees did not have large numbers (and were unlikely to respond to the request for written submissions) they had a number of high health and other social needs that should be identified and responded to.

Language, and the lack of appropriate translation services, was a major barrier for access to services, particularly for general practice services. Refugees often did not understand the health services in New Zealand and would seek treatment from hospitals rather than from primary health care services because this had been the norm in their countries. Several participants in the groups suggested that the skills of members of refugees, some of who had had health training in their native lands, should be called on for assistance in translation and providing information.

Access to mental health services was a particular problem for refugees, many of whom had had traumatic experiences including torture or other mistreatment in their homelands. Most also came from cultures that did not recognise mental health problems. General practitioners who worked with them often lacked skills to recognise mental problems and this problem was exacerbated by the language barrier.

Most refugees were poor and often unable to obtain work in their previous skill areas. However refugees were only entitled to specialist help for a short while and then had no rights to special assistance after this. Access to the services they were entitled to was often difficult as they had few resources, and language was a problem. One provider suggested that the adoption of capitation by general practice could lead to significant improvement in access to services.

Several refugees observed that it was important for refugees to develop resources where they could provide assistance to each other. One person mentioned a centre that they had established for doing this which could assist in reducing a refugee's need for other services. However it was difficult to obtain financial assistance for starting such centres.

The providers group thought that it was important to build on the work they had already begun with the Health Funding Authority, rather than beginning the process of developing plans again.

We have submitted a comprehensive plan for refugee health needs. We want the different departments to work together for these as in Strengthening Families. It won't work otherwise. We are good at theorising and producing documents. Now we want to see some action (General practitioner)*.*

Services for Asian people and other immigrants

The particular needs of Asians were addressed in two specially organised groups (one with service providers and one with representatives of the Asian community). A few written submissions also addressed the needs of Asian and other immigrants.

As for refugees, language was often a major barrier to access to services. The need for translation services for services in secondary and primary health care services was stressed by participants. Some also identified the need for written material on health and social services in Asian languages. Canada was cited as a model in this area.

There were sometimes providers who could speak people's native languages, or groups providing support for them. Providers sometimes organised health days for their communities where they gave their time to provide information and sometimes screening services. However they observed that there were costs involved although time was given voluntarily but the Government provided only limited financial support for the development of these services. One provider observed that she thought there was a mistaken belief that all Asian people were well-off.

Many of the participants in the groups supported the development and ongoing support for support services in hospitals and the community for Asians for primary and secondary services. A few Hospital and Health Services were supporting such services but many did not although there were significant number of Asian people in many parts of New Zealand.

Some noted that there were trained health providers available from Asian countries who could not obtain registration in New Zealand. Several supported

increased assistance for these people and a few wondered whether some of the barriers were based in racism rather than logic.

A number of areas where services could be improved for Asian people were identified. These included:

- ?? Smoking was a major problem with many Asian peoples and assistance with purchasing of nicotine patches would be useful. One provider observed, 'We have to say to them that you are the wrong shade of brown.'
- ?? Mental health was a problem for some Asian people, especially as they came from cultures which did not acknowledge mental health problems. Language was a particular problem here and support services would be very helpful.
- ?? Knowledge of the New Zealand health system for new immigrants would increase appropriate access to appropriate services. Access to information about conditions in the native language was often available through services like the Internet and providers assisted with medical translation but only have limited amount of time and no financial support. However, this did not provide information about the New Zealand health system.
- ?? Appropriate services for the elderly were important but some services such as social working services were inadequate and not culturally appropriate.
- ?? A greater emphasis on prevention services was necessary to increase Asian awareness of the services available such as screening. One participant observed that some Asian people were sometimes 'too aware' of such services and tried to use them more than necessary.
- ?? It was important to recognise that many Asian people would also use traditional medical services and it was necessary for 'mainstream' providers and traditional healers to learn to work together.

Appendix 2   New Structures

Appendix 2 of the discussion document outlined the new structure of the health sector and outlined the new roles of the Ministry of Health and District Health Boards. Around 50 percent of responses commented upon the changes and, although not of direct relevance to the NZHS, the responses have been analysed and a number of themes have emerged.

Concerns

Priority setting

The process by which District Health Boards will set priorities was queried. Some concerns were expressed that lobby groups representing strong interest groups would be able to unduly influence District Health Boards and affect the prioritisation process. This may impact badly upon minority groups.

Concerns that gains made may be lost

This was expressed by many small providers, that, because of their size, their services may be 'swallowed up' by others. There was general uncertainty as to how these providers would fit into the new structure. This point was not only made by Mäori providers, but also by others including: Pacific peoples' providers, mental illness providers and women's groups.

> *We are concerned that the gains made by the NGO health sector which is particularly focused on health promotion and disease prevention services may be slowed down significantly, compromised or lost altogether through an unravelling of the HFA work to fund and develop these* (287).

A number of Mäori providers made submissions and felt that the development of DHBs would adversely impact upon Mäori. One going so far as to state that:

> *DHBs are a threat to Mäori advancement* (411).

A number of the submissions concentrated upon the number of Mäori representatives on the District Health Board Board and advocating a 50:50 Mäori:non-Mäori split based upon the principles of partnership.

A number of groups also expressed concern that if national contracts were devolved to smaller District Health Board level contracts then this would adversely impact upon small advocacy groups.

<u>National coordination and consistency</u>

There were two key issues raised about national coordination and consistency. Firstly, concern was expressed in submissions at the mechanisms that would be in place to coordinate District Health Boards at a national level. A number of submissions declared the need for overall coordination and collaboration. A national organisation commented:

> *…the new structure with its 22 District Health Boards runs the risk of becoming a series of 'fiefdoms' with no overall national coordination.*

When discussing services to be provided or purchased by District Health Boards a second key issue was raised. Concern was expressed that a lack of coordination would lead to fragmentation, disparities between regions, and inefficient use of resources. One submission stated:

Some issues are bigger than local issues and need national coordination to assist regional providers.

A national organisation commented:

> *We are concerned about the very real potential for service fragmentation amongst District Health Boards, including duplication of contracts between District Health Boards and other providers…*

A number of submissions were concerned that the establishment of 22 District Health Boards would result in confusion and unnecessary expenditure. Some queried whether this would result in overlapping services and inconsistency. Some submissions raised issues about how 22 District Health Boards would interact with other agencies and organisations. There was concern at how District Health Boards would coordinate with government agencies, such as those responsible for housing, police, and education. There was concern expressed over the practicality of 22 District Health Boards establishing relationships with national organisations and smaller organisations. Some submissions expressed concern at how District Health Boards would link in with existing community structures. Some were also unclear about how national services would be funded under the new model.

A number of submissions expressed concern at the ability of District Health Boards to maintain relationships with iwi, especially in situations where the territory of one iwi includes several District Health Boards.

<u>Bureaucracy</u>

A number of submissions expressed concern that District Health Boards are going to be another layer of bureaucracy that will take funds away from 'front line' services.

<u>Issues around funding</u>

Funding was mentioned within a number of submissions, most making the point that funding issues are not mentioned in the document. Some submissions felt that this was a concern and that if the population health objectives outlined within the document were to materialise then there would need to be a redistribution of funding. There was concern expressed that funding for consultation was not detailed, that would enable to District Health Boards to carry out appropriate consultation.

Some submissions also commented upon the population-based funding formula and the effects it may have on certain parts of the country and on rural areas.

<u>Influence of HHS</u>

Several submissions expressed concern at the amount of influence that HHSs will have on District Health Boards. It was commented that with hospital boards becoming interim District Health Boards they might have undue influence in the longer term. Concern was expressed that the influence of HHSs on District Health Boards would encourage a strong focus on illness rather than on prevention and wellbeing. One submission stated:

> *Hospital dominance is rubber-stamped with the current Boards becoming interim District Health Boards.*

<u>District Health Boards as both purchaser and provider</u>

Some submissions expressed concern at reverting to the model that combined the purchaser and provider roles.

<u>District Health Board process</u>

Desire was expressed in some submissions that the District Health Board decision-making processes be open, and in particular that meetings be open to the public.

<u>Knowledge and skill of board members</u>

Many of the submissions discussed the knowledge and skills that board members should have. Some discussed those that they should not be required to have.

Support

<u>Less emphasis on competition</u>

A number of submissions applauded the focus of the document away from a competitive environment to one of collaboration. Some, however, questioned how easy it would be to actually do this. Some of these issues have been raised within the quality chapter of this document.

<u>Local decision making</u>

This area was commented on in a number of submissions. There was support for local District Health Boards making decisions that will affect the local community. There was also support for locally elected District Health Board members, although some submissions pointed out that there would be safeguards required to protect the interests of minority groups who may not gain Board representation.

Additional issues

One additional theme was that the sector should have a period of stability, that constant change of structures over the last 20 years has been detrimental to the sector. Many organisations find the constant change difficult to deal with.

Another area was ring fencing. Some submissions (principally public health and health promotion) wanted to see strong ring fencing to protect their services. Others thought that ring fencing should not happen at all in order to encourage cross-sector approaches.