KEEPING WELL 2008-12

WELLINGTON REGION STRATEGIC PLAN FOR POPULATION HEALTH

A report prepared for:

Ministry of Health
Wairarapa District Health Board
Hutt Valley District Health Board
Capital and Coast District Health Board

March 2008
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VISION AND GOALS

Keeping Well is a plan for the Wellington region to lift population health in especially Maori and Pacific wellbeing, by improving the performance of the population health sector.

Vision

Our vision is of a healthy population contributing to Wellington’s vibrant community and economy.

Purpose

The plan is designed to inform the Ministry of Health and three Wellington Region DHBs in their collaborative leadership of the sector, and to influence health providers and other organisations supporting population health.

Goals

1. Reduce health inequalities for the population groups most at risk
2. Support the development of healthy communities
3. Reduce the incidence and impact of chronic conditions

Strategic objectives

To make measurable improvements to regional health outcomes in the following eight population health priority areas:

1. Equal opportunity to good health
2. Smokefree living
3. Mental Wellbeing
4. Healthy Eating Healthy Action
5. Lives free from harm due to drugs and alcohol
6. Control of infectious diseases
7. Living conditions that nurture human health
8. Families enjoying violence free lives
EXECUTIVE SUMMARY

Background and purpose

*Keeping Well 2008-12* is a strategy for population health for the Wellington Region – the areas covered by Capital and Coast DHB, Hutt Valley DHB and Wairarapa DHB.

The strategy was commissioned because population health issues, communities of interest, providers and funding often cross the boundaries between DHBs and there are many areas where collaborative action makes good sense.

The purpose of *Keeping Well* is to guide collaborative DHB/MOH leadership for population health issues. The strategy provides direction for organisations working in the population health area, which include non-government organisations, Maori providers, local government, Pacific providers, Primary Health Organisations, the Regional Public Health Service, DHB providers, Government departments and others.

*Keeping Well* is based on widespread consultation and reflects the ideas of many stakeholders.

Aim and key issues

The aim of *Keeping Well* is to improve the health of the whole population and, particularly, to improve health outcomes for high needs groups.

Population health in the Wellington Region is relatively good compared to the national average. There are however health inequalities relating to Maori, and furthermore, to Pacific people, and people living in particular geographic areas.

Often the same groups experience the highest rates of risk and disease across many areas such as smoking, family violence, mental illness, communicable disease, poor nutrition, and alcohol and drug addiction.

Population health programmes are currently delivered by many capable organisations. The number of organisations involved with population health has increased dramatically over the last decade.

This broad involvement in population health is positive but in many cases there is limited shared planning, co-ordinated delivery or learning between organisations, which is inefficient and leads to a reduced impact on health outcomes.
There are different world views operating within population health, with Maori providers favouring a whanau/community based view, somewhat similar to Pacific provider views, whereas many other providers work with specific issues, such as smoking, nutrition or drug addiction.

There are sound working relationships between the three Wellington Region DHBs and the Ministry of Health (MOH). The three DHBs all have a similar approach to priorities and programmes and the MOH has signalled a desire to work more collaboratively with regards to funding and planning of population health services.

**Future direction**

*Keeping Well* supports obligations under the Treaty of Waitangi to improve processes of partnership, participation and protection in relation to services for Maori and acknowledges improving Maori health outcomes as a priority.

*Keeping Well* makes a number of significant recommendations to improve the performance of the population health sector.

**Acknowledge the world views of high needs communities**

Firstly, it proposes that if the focus for health improvement is on high needs populations then the approach to health programmes should better reflect the reality and world views of those populations.

The population health sector should focus resources on the determinants of health for whanau/family in high needs communities throughout the life course. This does not mean a shift away from evidence-based practice of the determinants of health, but recognises that effort needs to be concentrated on high needs populations and should support functional whanau/family structures – which are themselves a determinant of health. Stakeholders also identified the need to build core values around a strength-based approach. Linking to the world views of high needs populations will supportive more effective engagement with local communities in the design of health interventions.

**Address multiple needs**

Secondly, high needs populations often experience multiple risks and diseases. If the problems are joined up, the solutions need to be also.

It is proposed that instead of prioritising one health risk (such as smoking) against another (such as nutrition), the aim should be to develop a suite of effective interventions for all of the major risk factors. These interventions
can then be applied with a mix, level and balance appropriate to local population needs.

The following ‘priority areas’ are proposed, towards which the sector will focus effort on developing effective interventions. The priority areas are described as positive outcomes to align with a strengths-based approach.

- Equal opportunity to good health
- Smokefree living
- Healthy Eating Healthy Action
- Mental wellbeing
- Lives free from harm due to alcohol and drugs
- Control of infectious diseases
- Living conditions that nurture human health
- Families enjoying violence free lives

**Join up action and track progress**

Thirdly, new planning and funding tools are required to help support the development and implementation of each of the priority areas.

An outcomes framework has been developed for each priority area to focus MOH/DHB collaborative planning and funding, to support improved Key Performance Indicators for the whole system and to guide the actions of service providers.

Use of these tools will enable tracking of whole system performance and our progress towards achieving health goals.

**Build population health infrastructure**

Fourthly, lifting performance across the population health system – or network of organisations – is not a simple, policy, funding or management issue. It will require new ways of working for planners, funders and providers across many organisations, with a shift in focus towards working with high need communities.

Improvements to infrastructure are recommended in four key areas:

- Improve focus on inequalities and high needs geographic areas
• Improve the funding and performance environment
• Build knowledge and capability development
• Enhance leadership and communication

Implementation

Implementing Keeping Well will require collaborative leadership from the MOH and three Wellington region DHBs. It is proposed the Wellington Region Public Health Steering Group take on the leadership role with appropriate support.

A dedicated and time-limited project team will be required to plan and coordinate implementation.

Implementation should be phased, balancing clear collaborative leadership from the DHBs/MOH, and engagement with whole population health system encouraging locally-driven innovative responses.

The plan outlines key actions and the implications of the proposed direction for key sector organisations.

Values reflect best practice

Keeping Well is benchmarked against a set of best practice characteristics identified in international literature and confirmed by those who participated in the development of the plan.

The planning process has directly involved more than 150 stakeholders and reflects their views and insights. The process of building from strengths and creating networks and joined up action through open dialogue based on trust and mutual respect are core values expressed in the plan.

The plan identifies the importance of building from successful Maori organisations, as well as Pacific organisations, especially in high needs communities and the need for improved integration of health risk based interventions and holistic whanau based programmes.

Cohesive high-level DHB/MOH leadership will be vital to engaging other sectors, such as local government, in collaborative actions.
Outcome

Implementation of Keeping Well will support a more effective population health sector, leading to improvements in health outcomes, especially for high needs populations.
RECOMMENDATIONS

The *Keeping Well* plan makes the following key recommendations:

1. Focus on improving the health-giving qualities of the whanau/family environment and reducing health risks across a life course.

2. Target high needs geographic areas and influence the determinants of health that relate to populations in those areas.

3. Set priorities, but ensure that a balanced suite of interventions is developed across the major health risk areas.

4. Support an outcomes based approach, which frames collective action and measures whole system performance.

5. Develop improved infrastructure that supports the complex network of population health organisations

6. Encourage a strengths-based approach and learn from what is already successful.

7. Acknowledge and build from the strengths of organisations with community credibility.

8. Implement the strategy through collaborative high-level MOH/DHB ownership and leadership

9. Establish a dedicated project team with responsibility for implementing *Keeping Well*.

10. Initiate change through a process of dialogue with the sector, encouraging multiple locally-driven improvements that align actions with the strategic direction.

It is recommended that the Ministry of Health, Capital and Coast DHB, Hutt Valley DHB and Wairarapa DHB endorse this plan and commit to implementing the recommendations over the period 2008 to 2012.
A LETTER FROM 2012

This section is written to show how all the components of Keeping Well fit together. It is written from the perspective of 2012 looking back over the last four years.

We have been asked to look back on why the Wellington Region has made such progress in population health over the last four years, since 2008.

We have a feeling now that population health is ‘on a roll’. This is partly due to a collective sense of direction and also to increasing DHBs investment in population health initiatives. Right across the sector we seem to be getting to grips with how we work together and an emerging body of information about where we are working effectively. It is this emerging trust on the part of planners and funders that investment in population health will deliver measurable results that is leading to the increased funding for the sector.

Of course it is still early to really gauge progress on health outcomes, but our progress tracking measures are looking good and there has been a marked improvement in many of our measures for Maori people, particularly within our high needs communities. Improvements have also occurred in the Pacific population. How did this happen? Starting in 2008, we began to join up the bits of the population health sector.

First we joined up the leadership. Planning and funding across the MOH and DHBs was aligned so that there was improved understanding of sector issues, and an agreement on local priorities, funding and a commitment to improving sector infrastructure. The MOH/DHB leadership voice for Wellington region also built the high level bridges to other sectors like local government, social development and education which encouraged collective action on the determinants of health.

The last four years have also seen the blossoming of Maori and Pacific health providers. These organisation with close links to their local community, have been encouraged to develop holistic models which integrate whanau-focused activity, right through to advocacy and influence on the determinants of health.

A common commitment to a strengths-based approach has helped to mobilise Maori communities. Pacific communities have also committed to this approach, and encouraged us all to learn from what we are already doing well.

A key issue for the region has been getting away from siloed thinking about competing priorities based on various population health risk factors. Instead we are now looking at how we ensure there is a suite of effective
interventions that we can apply based on a community’s need and situation.

An important tool for achieving aligned action has been the use of collaborative outcomes frameworks. They have helped agree strategies across organisations, which has led to collective action and achieved a far greater impact. The commitment to recording whole system progress through robust tracking indicators and feeding this information back to all stakeholders has had an enormous influence in focusing action and on developing a learning environment.

One of the implications of this measurement process is a renewed trust in the population health system. Population health initiatives are a central part of the Wellington Region DHBs core investment strategies. One reason for this is that the CEO and Board of each DHB can now see the impact well designed programmes can have and so are more willing to back them.

One of the things many people comment on has been the process of change over the last four years. There is no doubt that the changes have been large, but they have been in many small steps. It has been a rapid evolutionary process, without major disruption. The origin of this approach was when the MOH and DHBs implemented the 2008 *Keeping Well* plan through a process of dialogue with the sector.

The communication led to an organic and grassroots-driven change process. When population health providers voluntarily bought into a direction forward, they self-organised around agreed priorities. This approach was supported by an explicit development of infrastructure including more evaluation, web-based tools to support cross sector communications, and improved contracting and funding methods that focused action and encouraged joined up activities.

Now that the population health sector is working together, we are finding we are better able to communicate with and influence other sectors which have an impact on the determinants of health.

In 2012 there are still unacceptable inequalities and areas we must improve, but we can track our progress and we are confident we have the infrastructure and ideas to make even more of an impact on health outcomes over the next four years.
1. BACKGROUND AND ANALYSIS

1.1 ACKNOWLEDGEMENTS

Keeping Well has been informed by the aspirations and ideas of the people in the Wellington Region population health sector. More than 150 stakeholders have contributed to the plan through interviews, focus groups and workshops. The issues and the solutions identified by stakeholders have guided our approach. Thank you!

A special thanks to the members of the Wellington Region Public Health Working Group, who provided invaluable guidance and critique in the development of this plan.

1.2 DEFINITIONS

Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.

In this document the population health sector refers to organisations that have a responsibility for the health of groups or populations of people. These include the MOH, DHBs, PHOs, NGOs, Maori providers, Pacific providers, local government and other government agencies with an interest in population health outcomes.

1.3 UNDERSTANDING THE ISSUES

1.3.1 Population trends and health issues in Wellington and Wairarapa

The Wellington Region population is made up of 39,000 people who live in the Wairarapa, 139,000 in Hutt Valley and 281,000 in the Capital & Coast area. The next 20 years will see a growth in the Maori, Pacific and Asian

*Public Health Agency of Canada
populations in the region and a substantial growth in the aged population across all ethnicities. (Please note that an analysis of demographic and population health trends is included in an associated document, the Wellington Region Population Health Profile).

The key health issues for the region are similar to those defined for the general population. Therefore, national priorities, policies and strategies are applicable to the Wellington population.

The MOH Public Health Intelligence Unit (PHI) undertook a needs analysis of three DHB areas in 2005, based on 2002/03 NZ Health Survey data and hospitalisation data. The table below ranks the five key population health issues identified for each district. All of the issues noted by PHI are national health priorities.

<table>
<thead>
<tr>
<th>Five major public health issues</th>
<th>Capital &amp; Coast DHB</th>
<th>Hutt Valley DHB</th>
<th>Wairarapa DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
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<td>Obesity</td>
<td>Alcohol &amp; drugs</td>
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<tr>
<td>Cardiovascular disease</td>
<td>Suicide§</td>
<td>Physical activity§</td>
<td></td>
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<tr>
<td>Nutrition</td>
<td>Cancer</td>
<td>Suicide</td>
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</tbody>
</table>

The population of the region is relatively healthy compared with other parts of New Zealand. However, there is significant avoidable morbidity and mortality that can be influenced through population health strategies.

There are disparities in health outcomes relating to Maori people. Disparities also affect health outcomes for Pacific people. A key feature of the Wellington region population is that there are many defined geographic areas with poorer health outcomes. The areas of high deprivation (deciles 8

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1 Please see the Wellington Regional Population Health Profile for a more detailed description of population health priorities and trends

4 Note that the inclusion of suicide as one of the five major public health issues for Hutt Valley appears anomalous; PHI’s analysis indicated that suicide rates in Hutt Valley were lower than most other DHBs in the Central Region in 2000-01, which was the period cited in their report.

5 Similarly, the inclusion of physical activity as a major public health issue for Wairarapa also appears anomalous; PHI’s analysis did not indicate marked inequalities for physical activity, nor were physical activity levels out of step with other DHBs.
to 10 using the 2006 New Zealand Index of Deprivation) are identified in the map below (darker brown shading indicates higher deprivation). (See Appendix 5.3 for additional maps which show distribution of Maori, Asian, Pacific and Other populations).
1.3.2 The population health sector

The population health sector is made up of many diverse and capable organisations. It is a sector that has undergone tremendous change and growth in recent years. Twenty five years ago the accountabilities for population health were mostly vested in a single Department of Health, with responsibility for policy and operational management. The pathway since then has been one of ever increasing complexity as more organisations have become involved with planning, funding and delivering services to address population health issues, as shown in the graphic below.

This increase in complexity of the population health system has been in part a response to a change in the key health issues and afflictions impacting on our population. We have shifted from a focus on communicable diseases and issues such as food and water borne diseases. Many of today’s health issues today such as diabetes, harm from alcohol and drugs, depression, family violence and harm from gambling are often
associated with our lifestyles, technological world and associated living conditions.

The increasing complexity of the health sector has also arisen from the need to deliver services that meet the needs of diverse communities. There are now many organisations with responsibility for population health outcomes outside the health sector. The population health sector now accommodates multiple world views about how to work with communities, especially high need communities. Maori and Pacific population health organisations, which have emerged over the last decade to provide tailored services to their communities, are strongly calling for greater recognition of their world views, and their values, and the voices of their communities in the design and delivery of health programmes.

Although the number of organisations with accountability for population health outcomes has grown rapidly over recent years, the infrastructure supporting ‘how’ the system works together has not kept pace. The system has shifted from one in which there was a clear hierarchy to one of a complex network, with multiple points of leadership, policy, funding and operational delivery. There is not currently the infrastructure in place to support effective linkages between these disparate elements.

The traditional population health world view is of various defined health risks impacting on a population and the need to modify those risks. The Maori world views places more emphasis on the role of the person as part of a whanau and within a community and the collective risks and determinants of health experienced by that whanau. Pacific peoples share a similar family focused world view. The graphic below shows the two world views

A diagram showing the two world views:

1.3.3 The planning and funding environment

The MOH and three Wellington Region DHBs are the main planning/funding organisations for population health. Whilst there is currently limited collective leadership and alignment of planning and funding between the
MOH and DHBs, the infrastructure is in place to support improved collaboration.

The three DHBs in the Wellington region share a number of common health concerns, fundamental goals and core strategies. These common strategic themes, outlined in the graphic below, describe useful foundations for developing a more consistent regional approach to population health services.

The MOH has recently reviewed its own function, role and value within the sector and has restructured to, amongst other objectives, provide an improved working relationship with DHBs and more focus on sector performance.

The aims of the MOH restructure, outlined below, provide an opportunity to develop more collaborative relationships between MOH and DHBs. They point to the need for a population health sector that is better focused on priorities and performance. The aims are to:

- Develop and provide advice to the Minister on the strategic and population health issues that affect the sector from a whole-of-system perspective
• Better respond to the sector’s needs (including non-government organisations and District Health Boards) to support performance improvements, operationalise strategy and share best practice and innovations across the system

• Sharpen accountability and monitoring of funding that is both within the sector and managed by the Ministry on the sector’s behalf, to achieve better health and reduced inequalities

• Strengthen our leadership and management capacity and capability to deliver on the Government’s priorities.

2. **Future Directions**

*Keeping Well* aims to provide guidance for the collaborative actions of the MOH and the three Wellington DHBs to improve the whole system performance of the population health sector. It also seeks to provide guidance for health providers and other organisations with an interest in population health.

The issues and ideas in this section are strongly influenced by the views of stakeholders within population health organisations within the region and by international best practice in the design of population health systems.

*Keeping Well* supports obligations under the Treaty of Waitangi to improve processes of partnership, participation and protection in relation to services for Maori, and acknowledges improving Maori health outcomes as a priority.

The recommendations and discussion in this section include a number of significant recommendations to improve the performance of the population health sector. These are included under four headings:

• Acknowledge the world views of high needs communities

• Address multiple needs

• Join up action and track progress

• Build population health infrastructure
2.1 ACKNOWLEDGE THE WORLD VIEWS OF HIGH NEEDS COMMUNITIES

If the focus of *Keeping Well* is to improve health outcomes for high needs communities then the population health approach should reflect the reality and the world views of those communities.

Population health strategies usually define priorities by particular risk factors (such as smoking or nutrition) or by population types (such as ethnicity or age group). However, most risk factors impact unequally on the same groups of people (Maori, Pacific, refugees, low socio-economic) who experience living conditions that mean they are vulnerable to multiple disease states. High need communities experience adverse living conditions throughout life, and often within the context of a whanau/family. Health risks accumulate over a lifetime impacting on morbidity and mortality rates at every life stage.

The population health sector should focus resources on the determinants of health for whanau/family in high needs communities throughout the life course.

Why a focus on whanau/family? A whanau/family approach resonates with high needs populations, especially Maori and Pacific people. It is very difficult to focus on specific groups, such as child and youth health, without a whanau/family centred approach. The whanau/family approach is also a way to access the health of older people for Maori and Pacific people. People from a whanau/family share the same genetic and environmental risk factors for chronic disease. The graphic below outlines the core focus of the approach, people within whanau/family, within high needs geographic community over a life course.
The priority does not mean a shift away from improving the determinants of health but recognises that effort needs to be concentrated on high needs populations and should support functional whanau/family structures – which are themselves a determinant of health.

A supporting focus on high needs geographic areas allows for more analysis and attention on the settings and determinants of health for those with the poorest health outcomes.

Stakeholders also identified the need to build core values around a strength-based approach. Stakeholders noted that ‘inequalities’ approaches usually point to what is wrong – not what is right or what is possible. The strength-based approach lifts the focus from specific risk factors to wellness and asks the question: What does it take for someone to keep well?

A strength-based approach mobilises resources wherever they occur and seeks to share successful approaches across individuals, families, communities and organisations. The approach supports a process of decentralised learning (learning from my neighbour) and so encourages organic learning environments.

A strength based approach seeks to understand and replicate local solutions. It can inspire and influence approaches at all levels of a population health system, for example:

- Understanding strengths in resilient individuals – not all people exposed to risk factors become afflicted with health problems.
- Some families face extreme stress but remain resilient and build their strength and cohesiveness – they even go on to share their ‘strength’ with others.
- Sometimes vulnerable communities mobilise on particular issues and self organise to achieve extraordinary outcomes e.g. Maori with kohanga reo
- Some organisations have embedded community trust and credibility. This strength may be more valuable than technical expertise when working in high needs areas.
- Iwi have strength in their mandate and guardianship role to advocate on behalf of many of the determinants of health.
- Pacific people have strong, connected communities built around their family and churches.
- Local government has a core set of ‘wellbeing’ objectives which align with health sector aims.
2.2 ADDRESS MULTIPLE NEEDS

The approach outlined in this strategy notes that many health risk factors are joined up. For example chronic disease can lead to depression, families may find it hard to modify their eating patterns when they are subject to violence, excessive alcohol consumption may impact on smoking cessation, or families may not be able to exercise when children have bronchitis due to poor housing.

If the problems are joined up the solutions need to be as well.

It is proposed that instead of prioritising one health risk (such as smoking) against another (such as nutrition), the aim should be to develop a suite of effective interventions for all of the major risk factors.

These interventions can then be applied in the mix, level and balance that is most effective for local population needs.

It is proposed that the following ‘priority areas’ are those in which the sector aims to develop effective interventions. The priority areas are described as positive outcomes to align with a strengths-based approach.

- Equal opportunity to good health
- Smokefree living
- Healthy Eating Healthy Action
- Mental wellbeing
- Lives free from harm due to alcohol and drugs
- Control of infectious diseases
- Living conditions that nurture human health
- Families enjoying violence free lives

The ‘priority’ areas defined above are at different stages of maturity in terms of their strategy development and implementation. For example, stop smoking programmes are mature public health programmes, as are communicable disease control strategies, whereas family violence and mental wellbeing are relatively new and ‘developing’ priority areas.

If the aim is to develop a suite of interventions, then the MOH and DHBs will need to support both the development of new services and the continuation of effective existing services.
The graphic below shows the proposed priority areas and whether they are mature or developmental areas.

2.3 JOIN UP ACTION AND TRACK PROGRESS
New planning and funding tools are required to help support the development of each of the priority areas and to join up thinking and action.

An outcomes framework has been developed for each priority area to focus MOH/DHB collaborative planning and funding, to support improved Key Performance Indicators for the whole system and to guide the actions of service providers.

The New Zealand Government strongly supports the use of outcome-based planning to ensure publicly funded programmes are linked to clear outcomes and that progress can be measured.

Outcomes frameworks describe how, over time, a set of inputs create actions that lead to outputs, then medium term outcomes and finally long term outcomes. Ideally there is an evidence-based and logical set of indicators to track the progress of results over time.

The outcomes frameworks proposed in this document and detailed on the following pages are quite simple. They distil multiple policies and stakeholder ideas into a small number of key strategies to focus resources, encourage collaborative activity and enable tracking of progress.

Where priority areas have mature programmes (such as tobacco, infectious disease) there can be a focus on defined actions. For the developmental areas (such as family violence, mental wellbeing) some of the actions are about defining the programmes, as they do not currently exist. Key actions are, therefore, about developing better local plans.

When working upstream or in areas of ‘determinants of health’ the ability to attribute particular action to outcomes is low. Therefore, interpretation will need to be at a more general level of ‘clusters’ of activities and their impact on ‘clusters’ of indicators. Also, when working upstream, progress indicators are more likely to be held outside the health sector, such as local government community wellbeing indicators.

The frameworks are structured in such a way as to show a flow from inputs to outcomes on the horizontal axis and a flow from a focus on determinants of health to personal care on the vertical axis.

The proposed outcomes frameworks should be viewed as ‘draft’ and as a starting point for a process of detailed engagement with stakeholders to collectively agree to the framework and indicators.
### Equal opportunity to good health

**Inputs**

**Long term outcomes**

**Tracking indicators 2008-12**

**Key action 2008-12**

#### Policies


#### Delivery

- Legislation, policies and strategies delivered by local and regional players including, DHBs, PHOs, Maori and Pacific providers, RPH, Tas, NGOs, MOH, other government departments, universities, communities

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<table>
<thead>
<tr>
<th>Policies</th>
<th>Key action 2008-12</th>
<th>Tracking indicators 2008-12</th>
<th>Long term outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whanau ora – Maori families are supported to achieve health and wellbeing</td>
<td>Basket of key proactive health measures (e.g. immunisation, well child checks, primary care access, avoidable hospitalisation) (Information Source: multiple sources)</td>
<td>Number of Maori and Pacific people participating in population health training (Information Source: training institutions)</td>
<td>Whanau ora values embedded</td>
</tr>
<tr>
<td>Pacific families are supported to achieve maximum health and wellbeing</td>
<td>Basket of key proactive health measures (e.g. immunisation, well child checks, primary care access, avoidable hospitalisation) (Information Source: multiple sources)</td>
<td>Strength based measures (e.g. whanau ora, Te Whare Tapu Wha) (Information Source: Local Government community indicators, quality of life survey, may also require new survey)</td>
<td>Stronger whanau, stronger communities</td>
</tr>
<tr>
<td>Develop Maori and Pacific population health workforce</td>
<td>Number of Maori and Pacific people participating in population health training (Information Source: training institutions)</td>
<td>Listing of research/evaluation in Wellington region focused on Maori/Pacific and population health interventions (Information Source: evaluation/research institutions, providers)</td>
<td>Healthier environments</td>
</tr>
<tr>
<td>Improve the determinants of health for high needs areas – environmental and psychosocial determinants</td>
<td>Strength based measures (e.g. whanau ora, Te Whare Tapu Wha) (Information Source: Local Government community indicators, quality of life survey, may also require new survey)</td>
<td>Listing of research/evaluation in Wellington region focused on Maori/Pacific and population health interventions (Information Source: evaluation/research institutions, providers)</td>
<td>Improved access to services</td>
</tr>
<tr>
<td>Enhance research and evaluation to develop the evidence base for effective population health interventions for Maori and Pacific peoples</td>
<td>Listing of research/evaluation in Wellington region focused on Maori/Pacific and population health interventions (Information Source: evaluation/research institutions, providers)</td>
<td>-</td>
<td>Improved health and reduced inequalities</td>
</tr>
</tbody>
</table>
### Smokefree living

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Key actions 2008-12</th>
<th>Tracking indicators 2008-12</th>
<th>Long term outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellington region promotes smokefree environments</td>
<td>Number/proportion of targeted 'smoking' environments becoming smokefree eg. parks, educational centres (measured by local government)</td>
<td>More smokefree environments</td>
<td></td>
</tr>
<tr>
<td>Collaborative research across the health sector, including universities focus on effective interventions for populations who still have high smoking rates</td>
<td>Research regularly disseminated to all smokefree providers Improved indicator set developed (measured through Annual Regional Smokefree Report)</td>
<td>Fewer young people start smoking</td>
<td></td>
</tr>
<tr>
<td>Comprehensive health promotion in high needs community focused on smokers, parents and children</td>
<td>Smoking uptake in youth (measured by Year 10 smoking survey) Smokefree homes and cars (measured by NZTUS)</td>
<td>More smokers quit</td>
<td></td>
</tr>
<tr>
<td>Increased use of brief interventions by primary care and midwives</td>
<td>Increased prescriptions for nicotine patches (measured by prescription rates) Use of cessation services (measured by contract outputs of cessation services)</td>
<td>Reduced tobacco related morbidity and decreased disparities</td>
<td></td>
</tr>
<tr>
<td>Implementation of hospital cessation programme linked with community services</td>
<td>Proportion of smokers receiving brief intervention prior to discharge (measured by hospital discharge information) Use of cessation services by patients discharged from hospital (measured by NZTUS)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Policies

### Delivery
Legislation, policies and strategies delivered by local and regional players including DHBs, PHOs, Maori and Pacific providers, RPH, TAs, NGOs, MOH, other Government departments, universities, communities.

- More smokefree environments
- Fewer young people start smoking
- More smokers quit
- Decreased smoking and less exposure to second hand smoke.
- Reduced tobacco related morbidity and decreased disparities
### Policies


### Delivery

Legislation, policies and strategies delivered by local and regional players including, DHBs, PHOs, Maori and Pacific providers, RPH, Tas, NGOs, MOH, other government departments, universities, communities

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Key action 2008-12</th>
<th>Tracking indicators 2008-12</th>
<th>Long term outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved coordination of HEHA services</td>
<td>District agencies achieving MAP milestones. <em>(Information Source: DHB HEHA quarterly reports)</em></td>
<td>Intersectoral steering group functioning effectively <em>(Information Source: DHB HEHA quarterly reports)</em></td>
<td>Increased motivation of individuals, whanau, social groups and organisations to support nutritious and LFSS options and to support and facilitate increased PA</td>
</tr>
<tr>
<td>Effective communication of HEHA key messages</td>
<td>Report on reach and impact of key measures <em>(Information Source: DHB HEHA quarterly reports)</em></td>
<td></td>
<td>Changing food consumption and PA patterns</td>
</tr>
<tr>
<td>Improve the food and nutrition environment in schools and ECEs</td>
<td>Education sub group operating effectively <em>(Information Source: DHB HEHA quarterly reports)</em></td>
<td>Number of nutrition fund proposals received/approved <em>(Information Source: DHB HEHA quarterly reports)</em></td>
<td>Reduced obesity/healthy weight throughout life</td>
</tr>
<tr>
<td>Support community-based HEHA initiatives for Maori and Pacific people</td>
<td>Number of active initiatives funded from community action grants for Maori/Pacific communities <em>(Information Source: DHB HEHA quarterly reports)</em></td>
<td>Number of Maori/Pacific people assisted to undertake training courses in nutrition/PA/health promotion <em>(Information Source: DHB HEHA quarterly reports)</em></td>
<td>Improved health and reduced inequalities</td>
</tr>
<tr>
<td>Contributing to progress on HEHA health sector targets</td>
<td>Breastfeeding - DHB progress on target indicators <em>(Information Source: Well Child, Plunket)</em></td>
<td>Number of community based HEHA initiatives that support fruit and vegetable consumption, with focus on high need communities <em>(Information Source: DHB HEHA quarterly reports)</em></td>
<td></td>
</tr>
</tbody>
</table>

**Note** – further work is needed on supporting improved physical activity outcomes
## Mental wellbeing

### Key actions 2008-12

<table>
<thead>
<tr>
<th>Policies</th>
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</table>

### Tracking indicators 2008-12

<table>
<thead>
<tr>
<th>Tracking indicators 2008-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop localised interagency plans for mental health promotion in high needs areas (Links with family violence and alcohol and drugs priority areas)</td>
</tr>
<tr>
<td>Plans developed and resourced (guidance from key stakeholders – including Maori and Pacific communities, (Information source: provider contract reports)</td>
</tr>
<tr>
<td>Improve whanau and personal knowledge and attitudes regarding mental health problems reducing discrimination and promoting early intervention</td>
</tr>
<tr>
<td>Strengths based wellbeing measures (e.g. whanau ora, Te Whare Tapu Wha) (Information source: may require new survey)</td>
</tr>
<tr>
<td>Improve mental wellbeing and resiliency in youth</td>
</tr>
<tr>
<td>Truancy (Information source: Ministry of Education)</td>
</tr>
<tr>
<td>A&amp;E and hospital youth discharges from intentional self harm (Information source: Hospital data)</td>
</tr>
<tr>
<td>Youth suicide (Information source: mortality statistics)</td>
</tr>
<tr>
<td>Improve culturally appropriate positive parenting skills and approach that support mental wellbeing in children</td>
</tr>
<tr>
<td>Number of active positive parenting programmes for high needs populations (Information source: Ministry of Social Development)</td>
</tr>
<tr>
<td>Referrals to CYFS (Information source: Ministry of Social Development)</td>
</tr>
<tr>
<td>Improve access and responsiveness of primary health care for people with mental health problems</td>
</tr>
<tr>
<td>Numbers of consultations for mental health within primary care (Information source: PHOs)</td>
</tr>
<tr>
<td>Acute service readmission rates from chronic mental illness (Information source: mental health services)</td>
</tr>
</tbody>
</table>

### Long term outcomes

- Increased community action
- Improved Whanau and personal skills
- Primary health services that are more appropriate to high needs groups
- Improved individual and community resilience
- Developing environments that support mental health
- Earlier access to support services throughout the life course
- Reduced morbidity and mortality due to depression and other mental illnesses and reduced disparities
Lives free from drug and alcohol related harm

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Key actions 2008-12</th>
<th>Tracking indicators 2008-12</th>
<th>Long term outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Increased community action</td>
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<td></td>
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<td></td>
<td>• Improved whanau and personal skills</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Health services that are more appropriate for high needs groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Improved individual and community resilience</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Environments Compliant with AOD legislation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Earlier access to appropriate health services for all people</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Reduced morbidity and mortality due to Alcohol and other drugs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Reduced disparities</td>
</tr>
</tbody>
</table>

**Policies**

- Minimising Alcohol and Other Drug Related Harm

**Delivery**

- Legislation, policies and strategies delivered by local and regional players including DHBs, PHOs, Maori and Pacific providers, RPH, TAs, NGOs, ALAC, MOH, other Government departments, universities, communities.

**Inputs**

- Strength-based wellbeing measures (e.g. whanau ora, Te Whare Tapu Wha) (information source: may require new survey)
- Police call outs and prosecution for assault where alcohol is involved (information source: Polic)
- Reduced morbidity and mortality due to Alcohol and other drugs.

**Key actions 2008-12**

- Develop localised interagency plans for lives free from drug and alcohol related harm in high needs areas (Note links to mental wellbeing and family violence priority areas)
- Ensure effective application of regulatory tools to control supply of alcohol and illicit drugs
- Working with alcohol supply and retail industry to promote responsible advertising and supply
- Improve whanau and personal knowledge and attitudes regarding addictive behaviours including drug use and alcohol consumption
- Improve access to appropriate primary health care services for people with AOD problems and maintain access to needle exchange services
- Practices with AOD screening/brief interventions (information source: PHOs)
- Referrals to AOD services (information source: AOD services)
- Convictions for alcohol sales to minors (information source: Police)
- Number of complaints to BSA and ASA, Number of Wellington Region complaints upheld (information source: BSA, ASA)
- Changes in knowledge attitudes and beliefs in high needs areas (information source: ALAC ... may need new survey)
- Incidence of blood borne viruses (information source: RPH notifications surveillance)
- Alcohol related mortality and discharge (information source: Hospital data)

**Tracking indicators 2008-12**

- Plans developed and resourced (information source: provider contract reports)
- A&E and hospital discharges from AOD related harm (overdoses, detox etc) (information source: Hospital data)
- Convictions for drug related crime and AOD related antisocial behaviour (information source: Police)
- Convictions for drug related crime and AOD related antisocial behaviour (information source: Police)
- Motor vehicle accidents with alcohol (information source: police)
- Motor vehicle accidents with alcohol (information source: police)
- Police call outs and prosecution for assault where alcohol is involved (information source: Polic)
- Reduced disparities
## Control of infectious diseases

### Long term outcomes
- Improved vaccination rates
- Decreased rates of infectious diseases
- Coordinated public health response to outbreaks

### Key actions 2008-12

<table>
<thead>
<tr>
<th>Policies</th>
<th>Delivery</th>
</tr>
</thead>
</table>

### Tracking indicators 2008-12

<table>
<thead>
<tr>
<th>Input</th>
<th>Key actions 2008-12</th>
<th>Tracking indicators 2008-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intersectoral (including schools housing, councils, DHBs, PHOs, RPH and community providers) health promotion programme in high needs community, focusing on prevention of skin and respiratory infections</td>
<td>Number of homes in high needs areas with adequate insulation and heating (measured by Healthy Housing Programme Evaluation)</td>
<td>Public awareness of measures to prevent skin infection and rheumatic fever in high risk communities (measured by – may require survey)</td>
</tr>
<tr>
<td>Region is able to respond to pandemic or severe epidemic of infectious disease (e.g. influenza)</td>
<td>Key agencies implement regular interagency training (DHBs, RPH, border agencies councils, PHOs) (measured by RPH reports on training)</td>
<td>Robust annual influenza surveillance and response (measured by RPH surveillance reports)</td>
</tr>
<tr>
<td>Focus on prevention of sexually transmitted disease</td>
<td>Development of interagency regional working group for prevention of STIs (measured by – group operational)</td>
<td>Culturally and age appropriate health promotion and treatment services are implemented and evaluated (measured by STI notifications and STI service outputs)</td>
</tr>
<tr>
<td>Improved vaccination rates in high needs communities</td>
<td>Percentage of children fully vaccinated at age 2 (measured by NIR data)</td>
<td>Percentage of high risk population vaccinated annually for influenza (measured by PHO data)</td>
</tr>
</tbody>
</table>

### Reduced incidence of infectious disease
- Decreased disparities and less morbidity from infectious diseases
Living conditions that nurture human health

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Key actions 2008-12</th>
<th>Tracking indicators 2008-12</th>
<th>Long term outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery</td>
<td>- Legislation, policies and strategies delivered by local and regional players including DHBs, PHOs, Maori and Pacific providers, RPH, TAs, NGOs, MOH, other Government departments, universities, communities.</td>
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</table>

**Key actions 2008-12**

- **Joint regional programmes of activity (Local govt, NGOs, Housing NZ, energy sectors) in high needs areas (Information source: provider contract reports)**
- **Levels/proportion of household overcrowding (Information source: HNZ)**
- **Levels of housing insulation and heat pump/pellet burners (Information source: Housing NZ)**
- **Sense of community (Information source: Quality of life report)**
- **Sense of personal neighbourhood safety (Information source: Quality of Life report)**
- **Feelings of isolation (measured by Quality of Life report)**
- **Uptake of implementing urban design protocols (Information source: local government)**
- **Completion of regional environmental health plan (Information source: RPC contract reports)**
- **Health impact assessments on major urban policies/developments (Information source: MOH/RPH)**
- **Recreational Water quality (Information source: RPH)**
- **Complete review of public health activity/influence in relation to supported living conditions and develop priority areas for engagement (Information source: provider contract reports)**

**Long term outcomes**

- **Strengthening cross agency coordination**
- **Improved sector responsiveness to issues**
- **Strengthening community infrastructure**
- **Healthier housing**
- **Stronger communities**
- **Healthier environments**
- **Healthy environments for supported living**

**Inputs**

- Levels/proportion of household overcrowding
- Levels of housing insulation and heat pump/pellet burners
- Sense of community
- Sense of personal neighbourhood safety
- Feelings of isolation
- Uptake of implementing urban design protocols
- Completion of regional environmental health plan
- Health impact assessments on major urban policies/developments
- Recreational Water quality
- Complete review of public health activity/influence in relation to supported living conditions and develop priority areas for engagement

**Tracking indicators 2008-12**

- Levels/proportion of household overcrowding
- Levels of housing insulation and heat pump/pellet burners
- Sense of community
- Sense of personal neighbourhood safety
- Feelings of isolation
- Uptake of implementing urban design protocols
- Completion of regional environmental health plan
- Health impact assessments on major urban policies/developments
- Recreational Water quality
- Complete review of public health activity/influence in relation to supported living conditions and develop priority areas for engagement
Families enjoying violence free lives

**Inputs**

- Policies

- Delivery
  - Legislation, policies and strategies delivered by local and regional players including DHBs, PHOs, Maori and Pacific providers, RPH, TAs, NGOs, MOH, other Government departments, universities, communities.

**Key actions 2008-12**

- Develop localised interagency violence prevention plans for high needs areas (Links with mental wellbeing and alcohol and drugs priority area)
- Health promoting schools programmes to promote zero tolerance of bullying and non violent alternatives to discipline
- Improve whanau and personal knowledge and attitudes regarding family violence, promoting recognition and appropriate intervention
- Improve responsiveness of primary care to family violence

**Tracking indicators 2008-12**

- Plans developed and resourced (guidance from key stakeholders including Maori and Pacific communities (Information source: provider contract reports)
- Number of schools with programmes in place (Information source: Ministry of education)
- Utilisation of anger management programmes (Information source: provider contract reports)
- Primary care practices trained in using family violence guidelines (Information source: PHOs)
- A&E and hospital discharge of injuries relating to family violence (Information source: hospital data)

**Long term outcomes**

- Increased community action
- Improved whanau and individual knowledge and skills
- Improved interagency coordination and accessible support services
- Environments that promote safe families and zero tolerance of family violence
- Improved and early access to support
- Health services that better meet the needs of the most vulnerable

**Stronger families and communities and reduced family violence**

**WELL**
2.4 BUILD THE POPULATION HEALTH INFRASTRUCTURE

Lifting performance across the population health system – or network of organisations - is not a simple, policy, funding or management issue. It will require new ways of working for planners, funders and providers across many organisations and for how all work with high need communities. The graphic on the following page describes key themes that have emerged from the consultation with stakeholders about how to improve the performance of the whole sector and the focus on Maori people, Pacific peoples and other high needs communities.
It is intended that each of the areas outlined above will drive a set of actions designed to make structural improvements to the population health system. The systems improvement areas fall into four key categories, with more specific recommendations under each category:

- Improving focus on inequalities and high needs communities
- Improving funding and performance infrastructure
- Improving knowledge and capability infrastructure
- Improving leadership and communications

Each recommendation has value in itself but it is the full set of improvements together that will create a new ‘operating system’, or ‘way of doing things’ for population health in the Wellington Region.

There are specific recommendations for the focus on high needs communities, which reflect feedback from stakeholders and aim to provide better integration of organisations and initiatives from an ‘issue based’ world view and those from a ‘community based’ world view.

A brief explanation of each of the recommendations is shown below:

### 2.4.1 Improved focus on inequalities and high needs communities

The three focussed recommendations below are aimed at encouraging the wider sector to prioritise inequalities and to take a community focussed approach in working with high needs populations and areas.

**Prioritised funding for collaborative initiatives in high needs areas**

Funding should be prioritised (in terms of programme-based funding and infrastructure development) for initiatives focussed on high needs populations and high needs geographic areas. There should be signals that funding approaches will favour collaboratives of organisations which can show that they are bringing together community credibility and technical skills in programmes that address risk factor reduction in a manner that is meaningful for the recipient community.

**Refocus strategy around organisations with community credibility**

Organisations with close community links should be more thoroughly involved in programme design and delivery for the communities they represent. Collaborative action is required to avoid uncoordinated siloed
strategies being directed at high needs communities. Community rooted organisations, such as Maori and Pacific providers, need to have an elevated status within the system and greater say in how the communities they represent receive information and services. They also should be encouraged to work with communities to develop advocacy on determinants of health.

**Revise programmes to reflect whanau ora outcomes and principles**

Whanau ora can be thought of simply as family health or it can reflect a deep view of Maori values and structures of engagement, as described in *He Korowai Oranga*. The deeper whanau ora principles and values need to be realised within networks, relationships and programme design. Whanau ora measures should be developed to ensure programmes are achieving progress meaningful to Maori communities, rather than service providers.

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2.4.2 Improved funding and performance infrastructure

**Agreed outcomes and tracking indicators across priority areas**

Future actions should involve taking the priority areas and outcomes frameworks developed in this strategy then building more detailed approaches with the stakeholder organisations. Participation in design will build collective ownership of directions and reinforce functional networks. The clear feedback from all levels (grassroots providers to DHB Boards and committees) is that detailed top down programmes do not engage with the sector.

**Collaborative and transparent funding across DHBs and MOH in priority areas**

The MOH and DHBs need to share information on funding allocations and contracts with a view to developing a trusting and transparent approach to funding. Clear and aligned funding signals should be provided to the sector. MOH and DHBs should be proactive in keeping the sector informed about where the population health funding is currently going and the implications of prioritisation decisions.

**Longer term contracts based on outcomes frameworks in priority areas**

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The MOH and DHBs should review contracting procedures to develop long term contracts that align with outcomes frameworks. Long term contracts allow for investment in workforce and organisational capability, they reduce unnecessary competitive relationships and enable programmes which can be properly designed and measured over time. Contracts should reflect the broad objectives and context outlined in this plan.

2.4.3 Improved knowledge and capability infrastructure

**Improved evaluation and sharing of best practice across priority areas**

There should be a concerted effort by all organisations to build a common learning framework for each priority area – and where appropriate for high need populations and locations. Many population health interventions are only partially evidence-based – particularly in the process of implementation. Interventions that are not evidence-based must be 'learning framed'. This is particularly true for interventions with Maori populations, as we generally cannot look overseas for guidance. Investment is required in developing evaluation skills within organisations and in quality external evaluations and in the development of knowledge sharing structures. We suggest that the Canadian ‘knowledge broker’ framework is explored in this regard. A trusting and respectful relationship with community knowledge, particularly for Maori, will be critical.

**Support increasing use of evidence in designing interventions in priority areas**

Basing programme designs on evidence is a central component of best practice in population health. Designing programmes based on evidence often requires advanced technical skills, generally obtained at a post-graduate level. However, as the number of organisations involved in delivering population health interventions grows, many people designing programmes do not have formal training. There is also often a tension between a world view of the value of (often overseas based) evidence versus ideas that emerge from community consultation. There needs to be a mechanism to provide programme design support for those organisations which do not have access to technical expertise. However, this must be tempered with acknowledgement of, and respect for, the importance of a deep knowledge of local community needs and capabilities. The increased use of evaluation will support learning about how best to integrate evidence and community knowledge in effective programme designs.

**Developing workforce skills in priority areas**

In many population health areas the factor limiting progress is not funding but the availability of a suitably qualified and stable workforce to deliver. A
strategy is required to ensure there is an understanding of the workforce needs for each of the priority areas and for developing appropriate training and ongoing support. The implications of the ‘systems improvements’ recommendations in this paper will also have implications for required workforce skills. The Wellington approach needs to link to the broader NZ-wide public health workforce strategy.

2.4.4 Improved leadership and communications

Building informed leadership networks in priority outcome areas

Population health is a complex system of networks. Functional networks are highly effective and efficient ways to communicate and coordinate activity in complex systems. Non-existent and threadbare networks mean that communication can only occur through what are often cumbersome formal channels – or not at all. Networks build through processes of knowledge, trust, respect, value and face to face relationships. Systems and structures need to encourage network formation. There is also a need to support networks through improved sharing about what programmes/services the various population health organisations deliver. Web based tools can help efficiently collect and communicate this information.

Create clear leadership and accountability for implementing changes in priority areas

As the population health sector has become more complex, leadership has become diffused. There is a need to rebuild clarity about roles and responsibilities. The Regional Public Health Steering Group needs to be supported to create stronger strategic and operational leadership for the sector. Primary care leadership at the MOH may wish to join the group to ensure there is alignment with the strategic direction for PHOs. Accountability for implementing this plan should fall to the Regional Public Health Steering Group and key decisions about regional strategy, funding, infrastructure and performance should be made by the group. The group will provide guidance on which issues require district-based or regional-based decisions. The group should build a profile as the key population health leadership node in the sector.

3. IMPLEMENTATION

3.1 IMPLEMENTATION LEADERSHIP AND PROCESS

Implementing this strategy is a significant challenge. As noted earlier, the population health sector is a complex network. It will not respond to ‘command and control’ leadership but rather to stimuli such as word-of-
mouth communication, a sense of belonging and excitement about being part of future opportunities. Inclusive leadership, communication, openness, trust, acknowledgement of diverse world views and transparent decisions will be vital to maintaining an engaged sector.

It is important the implementation is owned at senior levels of the MOH and the three DHBs and adequate resources are applied to properly support a complex implementation programme that will influence, funding, contracts, infrastructure, relationships, programme design and evaluation. The focus on high needs groups such as Maori and Pacific people, will need to be reflected with appropriate representation and expertise in governance and management structures.

The following high-level implementation recommendations are made, acknowledging that a more detailed plan is required.

3.1.1 Leadership

It is recommended that the Wellington Region Public Health Steering Group configure itself as the accountable body for implementing Keeping Well.

The steering group may wish to review its membership to ensure it has the right representation for the discussion/decisions required during the implementation process. A Wellington Regional Public Health Working Group, made up of sector representatives, was established to help in the development of this plan. A similar working group should continue to exist and have an important role as a source of independent advice and review during the plan implementation. Cross sector leadership hubs and networks should be encouraged to develop around the priority areas and around high needs geographic areas. Terms of reference for the steering group/working group will need to be drawn up.

3.1.2 Ownership

Once processes of review are complete, the steering group should seek to have Keeping Well endorsed by DHB Boards and by the MOH Executive Leadership Team and the Director General. Endorsement of the plan will provide the platform for a process of ‘collaborative planning and funding’ between the MOH and DHBs in relation to population health services in the Wellington Region. Keeping Well will support alignment of DHB planning documents, such as District Annual Plans, with MOH programmes and funding streams.

3.1.3 Project management and resourcing

Implementing the plan will require strong and dedicated project management. It is recommended that a small, focused and time limited project team is set up to support the implementation of Keeping Well. The
The project team would report to the Wellington Region Public Health Steering Group and would work closely with the working group. A member of the steering group or their representative should be positioned to support the implementation team with operational issues. A project team of 2.5 FTE is proposed; one person with broad population health experience and skills, one person with project management skills and administrative support. It is proposed the MOH resource the project team for two years and then review. The graphic below sets out the proposed structure.

3.1.4 Project phasing and linkage

The early phase of implementation will need to put sound structures in place whilst developing good communications with the sector and quickly delivering tangible results.

There are many recommendations in Keeping Well that will require support for implementation. Important initial tasks include:

- Agreeing on the steering group structure and governance
- Obtaining endorsement for Keeping Well from DHBs and MOH
3.2 CHANGE MANAGEMENT APPROACH

The population health sector is a complex network of mostly small autonomous organisations, with few large government-owned organisations. Many of the connections in the system are via interpersonal relationships as opposed to formal organisational relationships.

<table>
<thead>
<tr>
<th>2008 (Jan – June)</th>
<th>2008/09 year</th>
<th>2009/10 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Configure Wellington Region Public Health Steering Group to take accountability for implementation of the plan</td>
<td>Support exemplar programmes in high needs areas</td>
<td>MOH/DHB funding aligned with agreed priority areas and reflecting high needs community needs</td>
</tr>
<tr>
<td>Plan endorsement (MOH/DHBs)</td>
<td>Review of contract outputs to align with outcomes frameworks</td>
<td>New RPH support roles operational</td>
</tr>
<tr>
<td>Set up sector reference group to advise implementation</td>
<td>Funding alignment across MOH/DHB in high needs areas</td>
<td>Workforce plan operational</td>
</tr>
<tr>
<td>Develop dedicated project team to drive key actions</td>
<td>Support for increased roles of community-linked organisations</td>
<td>Improved evaluation infrastructure in place</td>
</tr>
<tr>
<td>Develop detailed implementation plan</td>
<td>Introduce whanau ora indicators</td>
<td>Rolling out of joined-up initiatives in high needs communities</td>
</tr>
<tr>
<td>Maintain communications with sector</td>
<td>New roles for RPH around regional progress indicators, evaluation, support for programme design</td>
<td>Outcomes frameworks guiding investment and programme design</td>
</tr>
<tr>
<td>Begin working on exemplar projects in high needs areas</td>
<td>Review of intervention design in high needs areas</td>
<td></td>
</tr>
<tr>
<td>Begin work on collaborative review of outcomes frameworks</td>
<td>Regional population health workforce action plan</td>
<td></td>
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</tbody>
</table>

A detailed discussion on implementation has been prepared in the *Keeping Well Implementation Plan*. The graphic below shows a high level view of the implementation process over the next two to three years.
Trust varies significantly across the system, with many organisations still maintaining a somewhat competitive relationship, even though a strictly competitive environment does not exist.

Stakeholders universally note the desire to work more effectively with others to achieve greater collective effectiveness, but all point to the difficulty of collaboration and the many barriers.

The MOH and DHB provider contracts and PHO health promotion funding proposals contain the formal definitions of expected activity throughout the system. However, the contract specifications are not readily available, so there is a structured situation where many providers have to make decisions about programme design without knowing what others in the system are doing.

The process of implementation of Keeping Well should support a more open discussion about ‘what’s happening’. Organisations should be informed of how the relevant parts of Keeping Well impact on their areas of activity and should be encouraged to work with partner organisations, sharing information and making a series of small steps to align their existing services to the proposed strategic priorities.

Multiple locally-driven changes should be encouraged. The Keeping Well project implementation team should help to remove barriers and encourage local innovation that aligns with the with Keeping Well strategic direction.

4. IMPLICATIONS

Implementing Keeping Well has implications for many organisations involved in the funding/planning and delivery of the plan.

4.1 MINISTRY OF HEALTH

The MOH will need to develop a more collaborative approach with respect to planning and contracting for public health funding. This will entail the MOH working closely with the three Wellington region DHBs to agree on strategic and operational priorities, with a transparent approach to detailed funding allocations, contract specifications and performance measures.

The MOH should sponsor the project team responsible for implementing Keeping Well. The MOH has a role in ensuring meaningful tracking indicators are collected and disseminated to stakeholders across the region.
The MOH also needs to take the lead in engaging other government departments. For example, key to further development of the family violence area is building on existing relationships and/or partnerships with Ministry of Social Development and the Police.

MOH should engage in its new role of supporting the identification and spread of best practice across organisations.

4.2 DISTRICT HEALTH BOARDS

If the MOH is to work more closely with DHBs on population health infrastructure and strategies, DHBs will need to ensure they have appropriate strategic and operational commitment to respond. This may mean building capability inside some DHB funding/planning teams.

DHBs will need to focus on contributing to constructive debate on regional infrastructure and services as well as their own district-based jurisdiction.

DHBs will be required to show leadership in supporting development of integrated population health programmes for high needs areas and in building the capability of organisations with community credibility. They will also need to lead consultation with local communities.

DHBs will need to link the Keeping Well strategic themes with their own District Annual Plans. DHBs have a role in forming strategic partnerships with local government and aligning activity on influencing determinants of health. They also have a role in building local PHO capability to influence population health and to link PHOs with other networks of population health providers.

4.3 LOCAL GOVERNMENT

Local government should see Keeping Well as an opportunity to join forces with the health sector to more effectively influence community wellbeing outcomes and sustainable environments.

There are many opportunities to work together on initiatives at a broad level (such as urban design) and a focused level (services to a high needs community).

There is also an opportunity to share community and environmental wellbeing indicators and to develop joint targets.
Local government has much to offer health in terms of its infrastructure and community links, and also its community leadership through elected representatives. There is a need to commit to real tangible joint projects as a way of building health/local government relationships.

4.4 MAORI PROVIDERS AND IWI

Maori population health providers are a critical component of sector infrastructure. Maori organisations provide services across a wide range of population health areas and are responsible for many innovative community centred service designs based on whanau ora concepts.

*Keeping Well* supports an increasing focus on Maori health through:

- whanau ora as a central model for the plan
- increased focus on geographic areas where Maori live
- support for the further development of Maori health organisations. Maori health organisations in the region include both iwi and non-iwi by-Maori-for-Maori providers and Maori-focused services within mainstream organisations.

Maori should be involved in the further development of the *Keeping Well* implementation in line with the principles of partnership, participation and protection.

*Keeping Well* challenges Maori health organisations to take on a greater leadership role in the planning of population health strategies in high needs communities. *Keeping Well* has also highlighted stakeholder feedback about the greater potential role iwi could play as health promotion leaders, in advocating for changes to the social and environmental determinants of health.

New approaches to community wellbeing measures should be investigated, using the Te Whare Tapa Wha model or whanau ora indicators. Maori should be involved in the design and development of these services. Many non-Maori organisations acknowledge whanau ora models but are unsure what they mean in practical terms. Maori providers have a role in supporting mainstream organisations to better understand whanau ora approaches and the determinants of whanau ora.
4.5 PACIFIC PROVIDERS

Pacific providers have developed significantly in recent years and have achieved success with innovative models that combine public health and personal health services.

*Keeping Well* supports organisations with strong community credibility and highlights the need to focus on the family and community environments in high needs areas.

Pacific providers will be challenged to take further leadership; firstly, to develop strategies and skills to influence the determinants of health for their communities, and secondly, to work with other non-Pacific organisations to develop new models of integrated programmes for high needs populations.

These new programmes should leverage off the strength and credibility of Pacific providers and also utilise the resources and technical expertise of mainstream providers.

Pacific providers should ensure there are clear lines of communication with the MOH/DHB funder/planners so issues such as workforce development and programme evaluation receive timely support.

4.6 NON GOVERNMENT ORGANISATIONS

*Keeping Well* attempts to create an environment that supports a productive and sustainable NGO sector. The plan addresses issues of aligned funding, improved contracting, support for workforce development, evaluation, information sharing and a focus for collective action.

The NGO sector needs to respond with an understanding that, for many ‘issue based’ organisations, there may need to be changes in how they operate if they are to work together with other organisations within a whanau context and from a strengths-based approach. NGOs need to make more efforts to act in a collaborative manner with other NGOs and to build leadership networks around community need, not organisational boundaries.

NGOs also have to take more intellectual leadership for working within an outcomes-based paradigm and improving their ability to measure the impact of their activity.
4.7 PRIMARY HEALTH ORGANISATIONS

PHOs have an accountability for the health of their enrolled populations. One of the reasons for calling Keeping Well a ‘population health’ as opposed to ‘public health’ strategy was to ensure it was relevant to primary health care. The outcomes frameworks are designed in such a way as to indicate those strategies that link to personal health services.

PHOs have limited health promotion funds to create new programmes, but have huge capability to influence the focus and capability of general practice and other providers to have a greater impact on population health. Keeping Well outlines a number of specific areas where PHOs have a role in enabling general practice to support wider population health initiatives.

PHOs have a particular role in working in an integrated manner with other organisations in high needs communities, emphasising a whole family approach to primary care and linking local whanau needs to local action on the determinants of health.

4.8 REFUGEE SERVICES

The refugee community has recently completed a major collaborative planning exercise of its own that has resulted in a comprehensive plan: Wellington Regional Action Plan for Refugee Health and Wellbeing.

This plan is well grounded, supported by stakeholder organisations and the refugee community and is currently in the early stages of implementation.

Keeping Well supports the Refugee Health and Wellbeing Plan and advises that it should guide services for refugees and should be referenced when reviewing services for high needs groups.

4.9 REGIONAL PUBLIC HEALTH

The Wellington Regional Public Health Service (RPH) is a large organisation, which receives just over half of all the MOH public health funding for the Wellington region. Therefore, the capabilities actions of RPH have a large impact on population health initiatives.

RPH is an organisation in a period of transition from an environment where it was the core supplier of health promotion and health protection services to one in which it is one of many organisations working in the health promotion area. RPH has strengths in its critical mass and the technical expertise of its staff.

The focus of Keeping Well on improving the population health infrastructure opens new opportunities for how RPH can add value across the wider sector. However, the proposal to build from local organisations with
community credibility also poses a challenge for a regional health promotion organisation.

Keeping Well provides a number of new opportunities for how RPH can support the infrastructure modernisation programme and add value across the whole sector.

- Taking responsibility for collecting, analysing and disseminating information on regional progress tracking indicators on a regular basis. This would include building a sophisticated capability for measuring progress.

- Linking progress tracking with an evaluation capability to enable an improved understanding about ‘what is working’ and what is good value for money investment.

- Supporting the design of interventions with advice on the evidence base and input from technical experts.

- Undertaking focused needs analyses to inform strategies in high needs areas.

- Supporting collaborative initiatives in high needs areas, particularly with a focus on influencing the broader determinants of health for that community.

- Developing a more strategic role in workforce development, which may include links with training institutions. There should be an explicit focus on developing more Maori, Pacific and Asian people with health promotion skills.

- Supporting the development of regional networks for sharing best practice and supporting capability development.

RPH may also wish to reflect on its current range of services, and to ask whether it is the best placed organisation to deliver some of its health promotion services. It may be that some of the skills and resources currently invested in RPH could be equally well utilised by emerging population health organisations that are more integrated with the local community.

Keeping Well supports the retention of RPH’s regional role in health protection services.
5. APPENDIX

5.1 ABOUT THE AUTHORS

**Paul Stephenson** - is a partner in Synergia Ltd, a company specialising in public sector strategy. He has been the lead consultant on many significant population health strategies including Let’s Beat Diabetes for Counties Manukau DHB, Our Health 2020 for Auckland DHB and the HEHA implementation strategy for the Auckland region. Paul was previously a senior manager in public health in New Zealand and Australia. Leading the regional public health service in Auckland and as State General Manager of public health for Western Australia. Paul is an honorary senior lecturer at the University of Auckland, School of Population Health and is an appointed member of the Auckland DHB Community and Public Health Advisory Committee.

**Dr Lynne Lane** – MBChB, DComH, AFPHM - Lynne is CEO of Affordable Healthcare and has over 15 years experience in health services strategic planning, funding, and service management.

Lynne currently holds a number of positions. For the past 5 years, Lynne has been the Chair of the New Zealand Committee of the Australasian Faculty of Public Health Medicine (AFPHM) which sets standards and provides training for Public Health Physicians in New Zealand. She is also the Chair of the ProCare Public Health Advisory Committee, a member of the National Ethics Advisory Committee, and a member of the Counties Manukau District Health Board Community and Public Health Advisory Committee (CPHAC).

Lynne has previously held a range of senior positions in the health sector including National Director of Public Health for the Ministry of Health, member of the Board of Directors for PHARMAC, General Manager Public Health for the Central RHA and acting General Manager Funding for Auckland District Health Board. She also has 7 years experience in General Practice.

**Dr Adrian Field** – Adrian Field is a consultant at Synergia. Adrian’s background is in policy and research, spanning central and local government, district health boards, social science research, and the NGO sector. Adrian has a special interest in public health policy and health system performance. His consulting work focuses on public health, primary care and chronic disease strategies, best practice reviews, survey analysis and health impact assessment. In 2004, Adrian completed doctoral study examining urban policies and community resource access.
5.2 INTERNATIONAL BEST PRACTICE IN POPULATION HEALTH

The first step in developing a population health strategy for Wellington was to look at strategies and approaches in peer countries to better understand international best practice. A number of common themes emerged from the review. These themes, outlined below, have been adopted and used to guide the development of the Wellington Regional Strategy for Population Health.

Overarching principles: These resonate with the underlying strategies of the Ottawa Charter (strengthening community action, creating supportive environment, building healthy public policy, develop personal skills, reorient health service)

Evidence base: Strategies rely on a strong evidence base to identify priority areas and priority population groups.

Priorities: There is a determination to address health inequalities. Priorities identify key population groups and/or settings; and other overarching areas of focus. Common priorities include:

Knowledge, attitudes and beliefs: Strategies and programmes typically seek to raise awareness and motivate change towards healthier lifestyles, commonly at an individual level, but also drawing in families and social networks.

Environments: The places in which people live and work have critical impacts on the health of individuals and populations. Addressing the environmental determinants of health are key to improving population health.

Policies: Whether set through central or local government regulation, or through practices of the private and NGO sectors, policies fundamentally affect the environments through which people live.

Populations: These are the key population groups considered critical to the success of a strategy. Typical population prioritisations include ethnicity, age, area, or socio-economic status/deprivation.

Settings: Common settings include schools, neighbourhoods and communities, workplaces, and health services. Settings-based approaches complement population-based approaches, by working in the physical or social situations where key population groups are most likely to be reached.

**Outcomes:** Strategies have overarching goals, with clear objectives to be attained over short, medium and long-term timeframes.

**Stakeholder consultation and partnerships:** Stakeholder buy-in (including target population groups as well as practitioners) is seen as crucial to the success of any strategy. Building on support and engagement, intersectoral partnerships are seen as the critical vehicles through which health gains can be achieved.

**Investment:** Ensuring ongoing and appropriate levels of investment, and that investment is directed towards areas where the greatest gain.

**Organisational learning:** Strategies aim to develop capabilities and capacities in service providers and communities through a self-reinforcing process whereby organisations build a collective capacity to learn and apply innovation to programmes and services.

**Monitoring and evaluation:** Ongoing surveillance links with a variety of research and evaluation method to enhance ongoing programme development. Monitoring and evaluation are seen as key components of performance management, by identifying key outcomes at different levels of programmes. It is also recognised that for many programmes, the evidence base is still evolving; monitoring and evaluation therefore provides a means of identifying the effectiveness of population-based interventions.
5.3 POPULATION MAPS

Usually Resident Population

Māori

- 2% - 6%
- 7% - 8%
- 9% - 11%
- 12% - 19%
- 20% - 47%
- Nil

Quintile Classification of 2006 Census Area Unit population percentages
Usually Resident Population
Asian

- 0% - 2%
- 3% - 4%
- 5% - 8%
- 9% - 12%
- 13% - 32%
- Nill

Quintile Classification of 2006 Census Area Unit population percentages
DHB boundaries

**Usually Resident Population**

- **Other (incl. European)**
  - 27% - 75%
  - 76% - 84%
  - 85% - 92%
  - 93% - 96%
  - > 96%
  - Nill

Quintile Classification of 2006 Census Area Unit population percentages