



Public Health Advisory Committee

Te Rōpū Tohutohu i te Hauora Tūmatanui

A sub-committee of the National Health Committee

# HEALTH IS EVERYONE'S BUSINESS

## Working Together For Health And Wellbeing

A report to the Minister of Health on the implications of a changing context for public health in New Zealand

Public Health Advisory Committee  
June 2006

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## FOREWORD

Improving New Zealanders' health and wellbeing requires more than the provision of health services. Good health and the prevention of illness, and dealing well with disability, is significantly an outcome of the settings in which people live their lives. Diet, housing, safe neighbourhoods, clean air and water, access to transport, education and employment are just some of the factors determining overall patterns of health and well being.

Most of the central and local government agencies whose actions affect these settings lie outside the health sector. Collaborative action, a 'whole of government' response, is required if health is to be improved, illness prevented, and disability well addressed. Public health practitioners and agencies are well placed to lead or support such an approach. But their success will depend on other stakeholders accepting their share of responsibility for realising health improvements. Health is everyone's business.

Emerging epidemics such as diabetes or potential ones such as avian influenza have drawn new attention to the importance but real limits of curative approaches. These threats to health are already spurring innovative, collaborative, 'whole of government' approaches to prevention, approaches that also include the private sector and non governmental organisations.

This report is firmly grounded in such innovative thinking and action. It takes such developments as a guide to how health policy should evolve. Its concern is to identify some of the new opportunities for collaborative approaches to improving health and to explore the new capacities that public health and other agencies will require if these opportunities are to be realised. It is intended as an invitation to those inside and outside the health sector to develop fresh approaches to sustaining and improving health and wellbeing.

The report's overall goal is a new framing of health issues so as to focus on the importance of prevention and on the development of a 'whole of government' approach to improving the health of New Zealanders. Realising such a goal will require innovative, collaborative action by many different agencies. It will also require the development of robust approaches to 'learning by doing' so that policy makers and practitioners can quickly learn what difference their actions are making.

The committee's thanks goes to interviewees, opinion piece authors, those who made submissions on the opinion pieces and discussion document, those who attended the workshops, and others spoken to as part of this project. The material we had to work with was rich and thoughtful.

Geoff Fougere  
Chair, Public Health Advisory Committee

## GLOSSARY

Public health (action)	“Collective action for sustained population-wide health improvement” <sup>1</sup> and to reduce health inequalities. Responsibility for such action is not confined to the health sector but should include all sectors whose actions affect the health of populations. Populations can be geographic and/or defined by factors such as ethnicity, gender, age, sexual orientation, income etc.
Māori public health (action)	Action by Māori to improve the health of the Māori population. It includes an emphasis on addressing the determinants of health but also improving the responsiveness of the health sector to Māori aspirations. <sup>2</sup>
Population health	The health status of a group of individuals, including the distribution of those outcomes within the group. <sup>3</sup> In New Zealand population health action is most commonly used to refer to health service (including Primary Health Organisations) responsibilities for the health of groups of people.
Personal health	The health of an individual and/or family/whānau. Personal health services are provided to individuals and families/whānau.
Public health sector	Includes agencies and organisations that have public health functions and their staff.
Core public health sector	Includes agencies and organisations that have public health as a primary function.
Publicly funded health services	Health and disability support services funded from taxes, including public health services and personal health services.
Determinants of health	A continuum of factors that influence health, ranging from individual biological factors and behaviours, to the social, cultural and economic contexts in which people live, work and play.
Pandemic	A global epidemic
Whānau ora	Māori families supported to achieve their maximum health and wellbeing.

<sup>1</sup> Beaglehole R, Bonita R, et al. 2004. Public health for the new era: collaborative action for population-wide health improvement. *Lancet* 2004; 363 2084-6

<sup>2</sup> Ratima K, Ratima M. 2004. Māori Health Action: a role for all public health professionals. Opinion piece for the Public Health Advisory Committee

<sup>3</sup> Kindig D, Stoddart G. 2003. What is population health? *Am J of Public Health*. Vol 93, No3.

## EXECUTIVE SUMMARY

### Chapter 1 – Introduction

Because many of the strongest influences on health and wellbeing come from outside the health sector, effective action to sustain and improve the population's health cannot be solely the responsibility of the health sector. What people eat, their level of physical activity, their access to good housing, education and employment are only some of the important factors involved in determining health. Effective solutions to health problems often require collaborative action by key stakeholders joining together across sectors. While the public health sector is well placed to lead or support this collaborative approach, success will depend on other stakeholders accepting responsibility for the health consequences of their actions and for working with the public health sector to improve the population's health.

The growing emphasis on a 'whole of government' approach to problems, the new responsibilities of District Health Boards and Primary Health Organizations for the health of the populations they serve and of local governments for 'well being', create significant new opportunities for the further development of strong, collaborative approaches to public health action. So too the renewed awareness of the limits of curative approaches to diseases such as diabetes, re-emphasises the importance of effective, inter-sectoral, public health strategies for prevention.

The Public Health Advisory Committee has completed a project that explores these new opportunities and challenges for building a collaborative, prevention based approach to public health. Over the course of the project the committee has developed a set of approaches that provide 'building blocks' for improving overall health and for reducing health inequalities.

### Chapter 2 – Key players and their roles for health improvement

The complexity of the wider determinants of health and their interaction means that there is a large number of key players which have an impact on the health of the population. This chapter describes the current roles of these key players.

### Chapter 3 – Collaboration for health improvement

This chapter outlines the ingredients for effective collaboration and explores opportunities for collective action both within the health sector and across sectors.

In order to maximise new intersectoral opportunities for population health gain, investment needs to be made to create sustainable partnerships within the health sector and between the health sector and others, including central government agencies and particularly local government. For example, local government now has a wider responsibility for community wellbeing. This means that the goals of local government and those of DHBs now have much in common.

### Chapter 4 – Building capability for collective action

Skills required to work on the determinants of health, for brokering and catalysing interagency work and for evaluating programmes, are different from those required for fulfilling contractual obligations in more traditional public health action areas.

A greater capacity for these new ways of working is needed. This has strong implications for public health workforce development. More opportunities need to be provided to develop new competences with clear pathways for professional development.

Māori are under represented in public health decision-making roles. Māori public health workforce development needs to be a priority to ensure Māori input into decision-making processes. Capacity needs to be built in both the Māori and Pacific workforces.

### Funding arrangements

Funding arrangements may facilitate or limit the opportunities for collaborative approaches to public health action.

The relationship between public health providers and the centre should be one that balances the legitimate need for accountability with the flexibility to respond to emerging issues in innovative ways, including collaborative action.

Contractual accountability and monitoring arrangements are important and should be flexible enough to encourage innovation.

## Managing Information

Central leadership is needed to guide the management of information at a district or regional level, along with frameworks for collecting information to ensure consistency across DHB regions. This will help build a clearer picture of the national situation while also enabling DHBs to track how they compare with one another and to learn from each others successes and failures.

It is important that implementation of the Health Information Strategy ensures the development of information systems that also inform public health practice and facilitate the sharing of information both within the sector and with other sectors.

## Chapter 5 - Leadership for collective action

Health improvement across a population requires the individual and collective efforts of a range of agencies and organisations, and this raises the question of who leads and coordinates that effort.

At a central level, Ministry of Health leadership for intersectoral collaboration should build on the pandemic planning and Healthy Eating-Healthy Action models to broker collective approaches at central government level.

At a regional level, District Health Boards, with their Public Health Units, are currently the agencies best placed to coordinate and broker public health responses across agencies.

## Chapter 6 – Recommendations

**To improve health and wellbeing across all population groups and to reduce health disparities between groups, the Public Health Advisory Committee recommends that the Minister of Health:**

### 1. endorse the following approaches:

- a 'whole of government' approach in which central and local government agencies accept responsibility for health related outcomes of their actions
- increased attention to influencing factors outside the health sector ('the wider determinants of health') which can improve the population's overall health and reduce health disparities
- increased strategic capacity of public health agencies to identify new opportunities for health improvement, develop effective cross sectoral interventions and evaluate and learn from their outcomes
- increased operational capacity of public health agencies to establish and maintain collaborative ways of working across sectors and at national, regional and local levels to address the wider determinants of health
- mechanisms and support for central and local government agencies to assess the likely health impacts of their policies using techniques such as Health Impact Assessment
- improved mechanisms for information sharing across sectors and for monitoring for effectiveness of joint actions
- strong recognition of the need to involve Māori at every level of public health and to increase Māori capacity and capability to respond to Māori public health needs
- greater flexibility of funding streams to encourage innovative intersectoral public health approaches
- as a medium term goal, the implementation of the above should lead to the development of a national strategy for health and wellbeing gain agreed and owned across sectors.

### 2. request the Ministry of Health to report to you in six months with proposals and timeframes to implement approaches that would enable the Ministry to identify:

- the intersectoral collaborations with which the Ministry, District Health Boards/Public Health Units, non-government organisations and Primary Health Organisations have been or are currently involved, the difficulties and opportunities these have presented and what has been learned from them

- further intersectoral opportunities for effective collaborative action at national, regional and local levels which can improve overall health and reduce health disparities.
  - the organisational capabilities required if these opportunities and emerging future ones are to be realised.
- 3. request that in preparing its report to you in six months, the Ministry of Health consider the options for action that the PHAC has identified in Chapter 6 of this report as having merit.**



# CHAPTER 1: INTRODUCTION

Good health and wellbeing enhances the lives of individuals and families. It also contributes to a productive economy and dynamic communities.

In October 2004, the Public Health Advisory Committee (PHAC) recommended to the Minister of Health that the New Zealand Government adopt the goal of “improving the health of all, without distinction for ethnicity, social or economic position, to the same level as those who have the best health”.<sup>4</sup>

This advice to the whole government was in recognition that the health of the population and health inequalities are not primarily determined by health services or individual lifestyle choices, but by the social, economic, cultural and environmental contexts in which people live, play and work. Although personal health services are crucial to the control and management of disease in individuals, they have a limited role to play in health improvement across the whole population.

To improve health and avoid health care services being overwhelmed, a focus on the promotion of health and prevention of disease is necessary. Personal health care services are necessarily reactive to demand. Public health approaches proactively aim to prevent ill-health and improve the health of the population.

### **Investment is needed in these proactive approaches.**

A focus on the social and economic environments in which people make their choices about their lives and wellbeing is required to make the greatest impact. This will involve responses coordinated across sectors to build healthy public policy, and create environments that support people to make healthy choices (public health approaches).

The diabetes example below demonstrates how control of the disease requires a societal response over and above the provision of treatment services.

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<sup>4</sup> Public Health Advisory Committee. 2004. *The Health of People and Communities: Public policy and the economic determinants of health*. Wellington.

## Example - diabetes

Type 2 diabetes is a preventable condition that leads to a number of adverse physical symptoms, is potentially fatal and has a strong linkage to obesity. It is a disease which can affect anyone but is more likely to show up in Māori and Pacific populations and low socio-economic groups.

Responsibility for addressing diabetes has traditionally been considered to lie with personal health services, which provide diagnosis, dietary advice and treatment to individuals in the form of insulin supplement, kidney dialysis and relevant surgical interventions.

However, the **control** of the diabetes epidemic is acknowledged as requiring an intersectoral response. A 'whole of society' approach will proactively seek to prevent the onset of diabetes using a comprehensive variety of strategies. Action will include the public health and primary health sectors providing healthy nutrition and physical activity programmes. It will also include working with other sectors, for instance:

- with local government to develop urban design that makes physical activity part of daily life
- with the transport sector to encourage healthy transport options
- with the leisure and fitness industries to increase access to physical activity
- with the food manufacturing industry to address fat and sugar content in foods
- with food retailers to reduce the promotion of foods high in sugar and fat
- with schools to provide healthy food and physical activity, and health education.

The health sector cannot provide all that is necessary for health improvement. Cross sectoral responses will be the most effective way of improving population health and reducing health disparities, in other words, achieving health gain.

This report describes the current state of relationships for health gain, and the necessary ingredients for effective co-ordinated work across sectors. It emphasises public health approaches that involve 'the organised efforts of society'.<sup>5</sup> It explores examples of good intersectoral practice, effective leadership and relationships, and makes recommendations for action. The report is firmly based in public health frameworks, including Māori models of public health and the Treaty of Waitangi.

## Challenges to health and wellbeing

**The challenges to health and wellbeing in New Zealand are similar to those affecting other countries and are a mix of old and new. But there are some differences, particularly in the way these challenges are addressed. In addition, New Zealand needs to rise to the challenge of reducing health disparities, particularly between Māori and non-Māori.**

Newly emerging communicable diseases such as avian flu and SARS present global challenges that need innovative solutions and collaborative interventions. The threat of another influenza pandemic is a current global challenge, requiring an enormous coordinated effort both within and between countries. In New Zealand the threat has catalysed co-operation across the whole of government and other sectors, providing a model for intersectoral collaboration and 'the organised efforts of society' (see Chapter 3 for more detail).

The ever-increasing chronic disease burden requires new approaches and new models for intervention. Obesity is a risk factor for a number of chronic conditions, such as diabetes and cardiovascular disease. Countries throughout the developed world are grappling with increasing obesity rates across populations, recognising that obesity is something that the health sector cannot deal with on its own. Co-operative effort is required. These new challenges and approaches require new skills and therefore have implications for workforce capacity and capability to respond.

<sup>5</sup> Acheson D. 1988. *Public health in England: A report of the Committee of Inquiry into the future development of the public health function*. London HMSO.

Other challenges to health originate in widening social and economic inequalities, resulting in whole population groups being left behind even as the overall health status of the population improves. In New Zealand, as well as the effects of socio-economic disparities on health, ethnicity presents an independent and significant effect. For example, being Māori or Pacific further increases the risk of death or ill-health across all socioeconomic categories. There is no easy solution to health inequalities but it is clear that collaborative effort which addresses the social and economic determinants of health is required.

The profile of public health issues has risen significantly in recent years, because of crises such as the outbreak of pandemics, and the intense media coverage of issues like smoking bans, increase in obesity, and food safety.<sup>6</sup> Public health is constantly, (sometimes controversially), in the public gaze, providing further challenges in the delivery of effective and appropriate responses.

Other social pressures such as change in family patterns, the aging population, the nature of work, and the loss of social cohesion, all influence the wellbeing of individuals and communities and provide increasing challenges into the future.

## Public health action meeting the challenges to health

**Public health action aims to sustain and improve the health of populations and to make sure no groups are left behind. It includes increasing the safeguards for the protection of the health of the population, for promoting its health and wellbeing, and for reducing the acute and chronic disease burden. It involves ‘collective action for sustained population-wide health improvement’<sup>1</sup> and recognises collective responsibility for population health.**

Historically, the health of the population has been protected by improved sanitation, water quality and food safety, and by vaccinating against infectious diseases (the ‘old public health’). In recent decades, the health of communities has been facing a series of new challenges. A rise in the relative importance of chronic diseases moved the focus of public health in the mid-twentieth century from a focus on sanitation to protect against infectious diseases, towards also including risk factors for chronic disease, such as smoking, diet and, physical inactivity.

This focus on the lifestyles of individuals was inadequate as an explanatory model. The approach put the onus on individual responsibility to make healthy choices without taking the context in which people make their choices into account. Both are important.

There is now a strong body of evidence that indicates that factors outside the health sector, such as poverty, housing and access to education, (the social and economic determinants of health) have strong influences on people’s lifestyle choices which then impact on their health.

**This creates a further challenge – how to address influences that are not under the control of the traditional health sector, but are of major significance for the health of populations.**

This challenge has led to the development of ‘the new public health’, where actions are guided by the Ottawa Charter for Health Promotion (1986), and more recently the Bangkok Charter (2005).<sup>7</sup> These international charters were convened by the WHO and developed by international public health expertise. They give guidance and direction to stakeholders about the most effective ways to promote health gain across the population and reduce disparities between groups and countries. The Bangkok Charter reaffirms the earlier Ottawa Charter and builds on it to take into account trends that have evolved since 1986, for example, the effects of globalisation, increasing urbanisation, and climate change.

In New Zealand these international charters lie alongside Treaty of Waitangi responsibilities to redress inequalities for Māori, and complement Māori models of health and public health action, such as *Te whare tapa wha*<sup>8</sup> model of

<sup>6</sup> Hunter D. 2004. Public Health function review in Northern Ireland: the policy context. A report commissioned by the Chief Medical Officer

<sup>7</sup> Both of these are international charters convened by the World Health Organization to develop some internationally agreed responses to challenges to the health of populations.

<sup>8</sup> Durie M. This model of health is holistic, based on four essential components of good health (the four cornerstones of the house (whare) – physical, mental, family and community, and spiritual health.

health and wellbeing and *Te Pae Mahutonga* model of public health action.<sup>9</sup>

Alongside these new public health challenges comes the information technology revolution, bringing with it new opportunities for public health in data collection, monitoring and consequent accountabilities.

## A new context for public health action in New Zealand

New Zealand's public health environment is going through a time of dramatic change both philosophically and in the creation of new settings for public health action.

### Philosophical change

Acknowledgement of the social and economic influences on health has been developing over the past several decades. It has led to the recognition that although the health sector can play a leading role, it can only be *part* of the solution to improve the health of the population as previously mentioned. Effective action to improve the population's health requires intersectoral approaches.

This has led to a re-evaluation of the scope and nature of public health action, and the ways in which different bodies and agencies can work together to promote population health. It involves seeking innovative solutions, making links across government and across sectors. It involves integrating public health concepts into strategic policy decisions and finding ways of engaging all the major players at both national and regional levels.

### New settings

During the past decade, new settings for public health action have been created as a result of changes both within and outside the health sector.

Purchasing and provider roles at a regional level have been re-integrated, and policy, operational and purchasing roles have been integrated at a national level.

The New Zealand Public Health and Disability Act 2000 created 21 District Health Boards (DHBs). The Act dissolved the Hospital and Health Services and the Health Funding Authority (HFA) and divided their responsibilities between the DHBs and the Ministry of Health. The Ministry of Health has inherited a purchasing role from the disbanded HFA, while still retaining the Ministry's policy and operational functions. Funding for personal health services has been devolved to DHBs to provide services at a local level, but public health services are still mainly funded through the Ministry of Health.

The creation of DHBs has significantly altered the health sector at a regional and district level, giving more responsibility to communities to identify health priorities. In addition, whereas the DHB predecessors were simply the providers of health care services and had no responsibility for the health of the population, DHBs do have that responsibility under the Public Health and Disability Act 2000. This responsibility cannot be met simply through the provision of health care services. Public health intent should therefore be strongly reflected in DHB planning and funding processes.

Twelve Public Health Units are contracted by the Ministry of Health to deliver public health services to one or more DHBs. Their relationships with DHBs are still developing and vary across the country.

More recently, the Primary Health Care Strategy has provided a new direction for primary health care with a greater emphasis on population health<sup>10</sup> and the participation of the community. Primary Health Organisations (PHOs) have been established and are charged with maintaining and improving the health of the communities they serve. PHOs have a separate funding stream for health promotion and are expected to take a population health approach in the delivery of their services. The relationship between PHOs and other core public health providers is still developing.

<sup>9</sup> Durie M. This model of Māori public health action is represented by the four stars of the southern cross (access to te ao Māori, environmental protection, healthy lifestyles and participation in society) and the criteria needed for effective public health action represented by the two pointers (leadership and autonomy).

<sup>10</sup> The term 'population health' is often used as a synonym for 'public health' but is in fact limited in its scope to actions taken by the health sector for improving the health of a group of people. It may also be used as a synonym for the 'health of the population'.

Māori/iwi and Pacific providers grew out of the reforms of the 1990s and are still relatively new. They, along with other non-government organisations (NGOs), have contractual relationships with a variety of funding bodies for both public health and personal health services. Many are directly funded by the Ministry of Health for public health action.

The Local Government Act 2002 has given local authorities a potentially greater role in public health (community wellbeing), and enhanced their ability to undertake public health actions. This creates more opportunities for intersectoral action but also provides some challenges to both local government and the core public health sector.

All of these changes are taking place in a political environment where there is an increasing emphasis on managing for outcomes, away from simple measures of outputs and processes. 'Whole of government' models of working are encouraged, in contrast to the vertical structures that were created in the 1990s.

In addition, the sustainability agenda has more currency than previously, incorporating many of the same values as those of public health. These include linkages between social, cultural, economic and environmental factors; and equity and wellbeing of current and future generations as key considerations.

**This time of shifting roles, responsibilities and structures generates new settings for public health action. These provide excellent opportunities for all those involved in public health – from established players to those newly exploring possible public health roles – opportunities for strong collaborative responses for public health action, with the consequent development of sustainable and productive relationships, based on transparency, trust and a shared commitment to improving the health of all New Zealanders.**

## The Public Health Advisory Committee project

It is this new and rapidly changing environment that has created new settings for public health action, which is the prime reason for the Public Health Advisory Committee (PHAC) undertaking this project.

The current landscape has evolved due to changes in the health and other sectors. The PHAC project explores how this new environment is impacting on the way that public health action is approached in New Zealand, how the new and existing players can take new opportunities to further the goals of public health by their interaction, and how public health capabilities and leadership can be enhanced at both regional and national levels. It identifies the challenges that this new environment presents and explores options for action.

Over the course of the project, the committee has developed a set of approaches that provide 'building blocks' for a way forward for health gain and improved wellbeing across all population groups, and for the reduction of health inequalities between groups:

- a 'whole of government' approach in which central and local government agencies accept responsibility for health related outcomes of their actions
- increased emphasis in the health sector on the wider influences on population health gain and reducing inequalities (the wider determinants of health and health disparities)
- increased agency capability and capacity to establish and maintain collaborative ways of working across sectors to address the wider determinants of health
- strong public health leadership to broker public health ideas and to catalyse public health action between sectors, occurring at central, regional and local levels
- mechanisms and support for central and local government agencies to be able to assess the likely impacts of their policies using techniques such as Health Impact Assessment
- improved mechanisms for information sharing across sectors and for monitoring for effectiveness
- increased strategic capacity of public health agencies to identify key public health issues, advise on effective interventions and evaluate their effectiveness
- strong recognition of the need to involve Māori at every level of public health and to increase Māori capacity and capability to respond to Māori public health needs
- greater flexibility of funding streams to allow for innovative intersectoral public health approaches.

As a medium term goal, the implementation of the above should lead to the development of a national strategy for health and wellbeing gain agreed and owned across sectors.

The following report will discuss the ingredients needed to achieve these and to take new opportunities for collaborative approaches for the improvement of health and wellbeing.

# CHAPTER 2: THE KEY PLAYERS AND THEIR ROLES FOR HEALTH IMPROVEMENT

Contributions to the improvement of population health and wellbeing are complex, given the inter-relationship of the wider determinants of health. This means that there is a large number of key agencies, organisations and sectors which have an impact on the health of the population, and which have the potential to contribute to health improvement. These key players are those that have the potential to capitalise on the new opportunities provided by recent changes that enable collaborative approaches to health improvement. This chapter describes the current roles of these key players.

## Sectors with public health action as a primary function

### Roles at a national level

#### *Ministry of Health*

The Ministry of Health is responsible for ensuring the health and disability system works for New Zealanders. It is the Minister and Government's primary advisor on health policy and disability support services, and is also responsible for policy advice on improving health outcomes, reducing inequalities and increasing participation.

The Ministry of Health's Public Health Directorate (PHD, the Directorate) administers public funding for public health action through contracts with Public Health Units and national non-government organisations (NGOs). The Directorate identifies its responsibility as covering 'public health policy and strategy development, including regulation for public health and safety, and the planning and funding of non-regulatory public and population health services'. Its eight functions are:

- providing leadership for public health action
- developing and implementing public health policy
- developing and implementing public health programmes
- planning and funding public health services
- managing emergent health risks
- collaborating across the public health sector
- leading public health sector development
- monitoring DHB public health and population health performance.

While responsibility for funding and managing most health services was devolved to DHBs under the New Zealand Public Health and Disability Act 2000, public health has remained a responsibility of the centre. Apart from the Directorate's business units (National Screening Unit, National Radiation Laboratory, Medsafe and Public Health Intelligence) PHD does not itself provide public health services but contracts them out to Public Health Units, other Crown Entities, NGOs and other providers.

The Directorate has recently established an Office of the Director of Public Health which has a clear mandate to work

across sectors.

The Directorate maintains locality offices which manage contracts with local providers in their region including those with the 12 Public Health Units across the country and a wide variety of other contracts including those of NGOs.

### *District Health Boards New Zealand*

The overall purpose of District Health Boards New Zealand (DHBNZ) is to assist DHBs in meeting their objectives and accountabilities to the Crown. This purpose assumes a role in facilitating engagement across the health sector. This gives DHBNZ an important function in facilitating the sharing of information about effective and innovative public health interventions, including the need for DHBs to address the wider determinants of health in a collaborative way.

### *National Non-government Organisations*

Approximately fifty percent of public health funding goes to NGOs to deliver public health services at a national, regional and local level. This makes NGOs important influences on the delivery of public health, especially as they have often represented the most stable part of the sector in recent times of change. In addition, some have contracts with other agencies besides the Ministry of Health.

Public health NGOs are mainly contracted to provide issue-based health promotion programmes or prevention services, for example, tobacco control, alcohol and other drugs, obesity, sexual health, or population based programmes such as Māori health, Pacific health or youth public health. Others are contracted by the Ministry to address wider public health issues such as the social and economic influences of people's health or public health workforce issues (Public Health Association and the Health Promotion Forum). These organisations represent collectives of individuals or organisations and are therefore able to represent collective views. They have been particularly active in building public support for healthy public policy, through health-aware legislation and public sector policy development.

### *Crown Entities*

Crown entities with sole public health functions include the Alcohol Advisory Council of New Zealand (ALAC)<sup>11</sup> and the Health Sponsorship Council of New Zealand (HSC).<sup>12</sup> Both crown entities use health promotion and marketing approaches to create environments that encourage healthy choices.

## **Roles at a regional level**

### *District Health Boards (DHBs)*

District Health Boards are key organisations for the delivery of health gain and for reducing health disparities. They were established under the New Zealand Public Health and Disability Act 2000 and are the main bodies for managing and delivering most health services. One of their objectives under the Act is to 'improve, promote and protect the health of individuals and communities' and another 'to reduce health disparities by improving health outcomes for Māori and other population groups'.

These objectives make clear that DHBs are required to engage in some form of public health action and incorporate a public health perspective as part of their statutory role. It is this public health perspective that will make the difference between a Board as merely the provider of treatment services and one that works with the community for health improvement.

Under the Act, DHBs are required to maintain a Community and Public Health Advisory Committee (CPHAC) to advise on health improvement measures. DHBs are also required to assess the health needs of their communities.

### *Public Health Units*

Public Health Units (PHUs) are the key vehicles through which DHBs mobilise public health expertise and provide public health services. There are 12 PHUs throughout the country, each attached to a 'host DHB', six of which provide services to two or three DHBs. For example, Community and Public Health is managed by the Canterbury DHB

<sup>11</sup> ALAC is a single issue agency whose primary objective is 'to promote moderation in the use of alcohol and to develop and promote strategies that will reduce alcohol related problems for the nation'.

<sup>12</sup> HSC's mission is 'to encourage New Zealanders to adopt and maintain healthy attitudes and lifestyles'. It covers a range of public health issues including tobacco, problem gambling, sun safety and 'healthy eating, healthy action'.

and also provides services to the West Coast and South Canterbury DHBs; Auckland Regional Public Health is associated with Auckland DHB but also provides services to Waitemata and Counties-Manukau DHB. The other six Public Health Units such as Nelson-Marlborough and Tairāwhiti provide services only to their host DHB.

### *Māori/iwi organisations*

Māori and iwi services are part of the NGO sector but need of special mention. They deliver health/public health services from an explicitly Māori perspective, sometimes by Māori for Māori and sometimes for the whole community. Many incorporate the delivery of public health services and approaches within a wider model of Māori-centred health and development. Philosophically, public health approaches are woven through aspects of whānau ora and personal health.

## **Roles at a local level**

### *Local non-government organisations*

Some of the large national NGOs have a network of locally based offices, such as the National Heart Foundation and the Cancer Society, and some exist only in the local community they serve. The former are funded nationally through the Ministry of Health or other central agencies; the latter are more likely to be funded locally. They tend to work with a community development model and are likely to be in close touch with their communities. Some of these local NGOs have become part of PHOs, some have themselves become PHOs, and others remain within the public health sector and are not part of the primary health system. Māori/iwi and Pacific providers work locally but are often regionally based.

## **Sectors with multiple functions including public health action**

### *Local government*

Local government has a wide range of functions including historical roles in public health. The Health Act 1956 has largely determined the traditional local authority public health regulatory role in drainage, sewage, water supply, public health emergency management, communicable disease and nuisance control. In addition, related legislation such as the Food Act, Sale of Liquor Act, Resource Management Act, Building Act, Civil Defence Act, Hazardous Substances and New Organisms Act and the Local Government Act has conferred powers on local government. Many of the early improvements in the health of the population have been attributable to local authorities improving drinking water quality and sanitation.

As noted in Chapter One, recent changes to the Local Government Act have increased local government flexibility to widen its public health role into social and cultural areas by requiring local authorities to ‘promote the social, economic, environmental and cultural wellbeing’ of their communities. The Act requires Councils to regularly work with the community to identify ‘community outcomes’ and to report on progress to achieve them. The new Act encourages a climate of collaboration and partnership between local authorities and other local stakeholders, increasing opportunities for collective action where there are shared goals. One of the shared goals comes from the considerable overlap between public health and social, economic, environmental and cultural wellbeing.

### *Crown agencies and entities with some public health functions*

Some central government agencies and entities have public health functions such as the former crown entity, the Land Transport Safety Authority<sup>13</sup> (now part of Land Transport New Zealand), the Department of Labour’s responsibility for occupational health and safety, the Accident Compensation Corporation (ACC)<sup>14</sup>, the New Zealand Food Safety Authority (NZFSA)<sup>15</sup>, and the Environmental Risk Management Authority (ERMA).<sup>16</sup>

Some of the functions of these organisations were originally led by the health sector – occupational health, food safety and management of hazardous substances – but have now been split off. The impacts of these changes has

<sup>13</sup> The Land Transport Safety Authority as a stand-alone entity is acknowledged as having been very successful in coordinating the reduction of the road toll. It has recently been incorporated into a new entity, Land Transport New Zealand.

<sup>14</sup> Part of the ACC’s role is to implement health promotion programmes to reduce accidents and injuries.

<sup>15</sup> The NZFSA is required to ‘protect and promote public health and safety’.

<sup>16</sup> ERMA’s mission is to “achieve effective prevention or management of risks to ... , public health and safety associated with importing or manufacturing hazardous substances and introducing new organisms, and their use.”

been mixed. The separation of occupational health from the health sector has not been effective for the monitoring of occupational disease.<sup>17</sup> The main focus of the Occupational Safety and Health Unit in the Department of Labour has been the reduction of occupational injuries and deaths. There is little monitoring or action in the area of occupational exposure to toxic substances or noise, for example, or of the development of occupational diseases.

### **Primary Health Organisations**

Established under the Primary Health Care Strategy, Primary Health Organisations (PHOs) are not-for-profit groups of providers whose main concerns are the primary healthcare needs of the people enrolled with them. The Primary Health Care Strategy specifies a population health approach for PHOs which are charged with maintaining and improving the health of the populations they serve. To this end the allocation of funding to PHOs includes specific amounts intended for health promotion activities. DHBs are required to approve PHO health promotion plans before they receive funding and then monitor their implementation.

The Primary Health Care Strategy provides opportunities for collaborative approaches to improving population health and wellbeing and reducing inequalities. PHOs provide a different setting for public health action to take place and can enhance the actions of government and non-government organisations rather than replace them.

PHOs will be limited in their involvement in public health action by their capacity to respond and their beliefs in what influences on health and wellbeing. If they believe that the health of the population is determined by social and economic factors, they will be more likely to work with other agencies in the areas of housing, poverty and employment. If they believe that health is more determined by lifestyle, genetics and medical interventions, then they are more likely to emphasise patient education and disease management.<sup>18</sup>

### **Sectors where public health action is not a primary function**

Sectors outside the health sector have a significant impact on health. For example, the actions and policies of Government sectors such as Housing, Social Development, and Transport, can and do play an important role in addressing (and potentially lessening) the health of the population. Similarly, schools, churches, marae, and the business sector (such as the food, and leisure and fitness industries) can be important vehicles for promoting (or lessening) health and wellbeing.

These agencies have multiple goals and functions and therefore do not see themselves as part of the core public health sector. However, in order to actively promote and protect health, it is important that these agencies consider the potential impact their policies may have on health and wellbeing. The health sector has a clear leadership role to engage these agencies in collaborative public health action and to assist them to assess policies for their potential impact on health and wellbeing and on health inequalities.

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<sup>17</sup> Pearce N, Dryson E, et al. 2005. Surveillance of occupational disease and injury in New Zealand: Report to the Minister of Labour Wellington: National Occupational Health and Safety Advisory Committee.

<sup>18</sup> Crampton P. 2004. The exceptional potential in each Primary Health Organisation: a public health perspective. Opinion piece on the relationship between public health and primary care for the Public Health Advisory Committee.



## CHAPTER 3: COLLABORATION FOR HEALTH IMPROVEMENT

**Many of the strongest influences on health and wellbeing and on health inequalities come from outside the health sector. Solutions which involve collaborative relationships between the key stakeholders across sectors are likely to be the most effective to improve population health.**

Some sectors outside health have goals involving improvement of the health and wellbeing of the population and therefore recognise the value of collaborating with the health and other sectors. For example, the local government sector has been quick to see the advantages of working with DHBs in order to address their responsibilities for community wellbeing. Local governments have not only provided opportunities for the health sector to participate in community outcomes processes, but some are also working with the health sector to assess policies for potential health and wellbeing impacts. This is recognition of the value of forming relationships to address common goals collaboratively.

Public health frameworks, such as the Ottawa and Bangkok Charters, emphasise the need for collaborative approaches to address the social and economic influences on health and health inequalities – the health sector can only be part of the solution. The New Zealand Health Strategy also emphasises the need for collaborative action. It states:

*‘If we want to make a positive difference to health, we will need to coordinate action across different areas of government and address a broad range of social, economic and lifestyle issues’.*

Te Pae Mahutonga states that ‘collaboration and alliances are critical in a small country such as New Zealand’.<sup>19</sup> The health/public health sectors will have key leadership roles in identifying potential areas for joint work and in catalysing collective action.

This chapter outlines the ingredients for effective collaboration and explores the opportunities for collective action across sectors and within the health sector.

### Criteria for effective collaboration

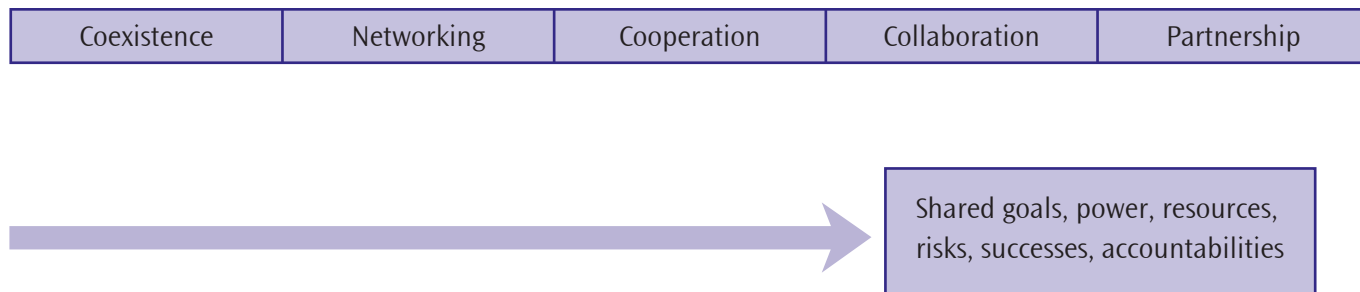
A focus on major public health problems will mostly, but not always, require intersectoral collaboration. For collaborative action to be effective, the PHAC has identified some fundamental criteria:

- the collaboration exists because the members share a common purpose that can be most effectively accomplished jointly (this will require the assumption of responsibility for relevant health outcomes by each of the agencies whose actions affect health)
- the funding and contracting environment supports collaborative action
- the workforce is skilled in initiating and facilitating collaborative action
- the collaboration shares power, resources, information and responsibility across its members

<sup>19</sup> This statement is in the context of the need for self-governance at local, marae, hapu, iwi and national levels, but explaining that this does not mean ‘separatism or total independence’.

- the members respect the values and cultures of the other parties
- trust and confidence is built through transparency of decision-making
- open dialogue is maintained with the aim of reaching agreement on common language, joint values, responsibilities and action plans.

Courtney and Craig (2004) describe collaborative relationships in terms of a ‘partnering continuum’:



## Relationships for collective action

Current structural arrangements across and within sectors provide significant opportunities for building relationships across sectors. This is especially true in the context of local government and health sector reform. There is increasing emphasis on ‘whole of government’ approaches and greater recognition that working together, although resource intensive, brings many direct and indirect benefits.

The PHAC has found that these opportunities are often not being realised due to factors such as: inadequate communication between players; a lack of clarity and guidance as to how these players can and should interact; a lack of acknowledgement by some players of how their actions affect health; a lack of capacity to respond; and problematic funding arrangements. This has led to a patchwork situation that contains pockets of excellent and innovative activity, but also fragmentation, duplicated effort and lost opportunity.

The PHAC has therefore focused its attention in this report on ways to realise opportunities to enhance collaborative relationships for improving health outcomes.

### Relationships at a central level

There are examples of collaboration between government agencies where the Ministry of Health has taken the lead. The most current and prominent example is the planning for a possible influenza pandemic which could be thought of as a ‘whole of government’ model for intersectoral collaboration, which has rarely been undertaken on this scale in New Zealand. The imperative to plan for such a situation has introduced a new way of working across government departments.

## Pandemic planning – an intersectoral model <sup>20</sup>

Knowledge of the 1918 influenza pandemic has been used to model the potential scope, scale and duration of an influenza pandemic. The model is based on a scenario where 40% of the New Zealand population would become ill over an 8 week period.

The plan is based around a sequential five-stage strategy:

- planning, to reduce the social and economic impacts
- border management, to keep the pandemic out of New Zealand
- cluster control, to control/eliminate any influenza clusters
- pandemic management, to reduce the effect of the pandemic on the population
- recovery, including recovery of population health and the resumption of normal services.

At a central level an Intersectoral Pandemic Group coordinates thirteen workgroups, each led by a key agency which coordinates action between all the other agencies in the working group. For example, Customs leads the border working group which includes Aviation Security, Maritime Safety Authority, ports, airports and Biosecurity.

Pandemic planning prepares New Zealand society for high levels of illness and the consequent difficulties in providing goods and services, the need to get information to the public, the reduced ability of the health sector to treat ill people and the consequent care in the home by family members, and the need to bury a high number of deceased people. The plan covers health care and emergency response including staff training, a communications plan, monitoring and surveillance, including where key decisions will need to be made.

This intersectoral approach is also reflected in agencies' responses at a regional level, coordinated by the DHB but including a wide variety of local government, central government, non-government and health sector organisations.

The Ministry of Health could build on this intersectoral model by taking other opportunities to lead collaborative work for the control of preventable chronic disease, as well as for communicable disease management. Examples of such collaborative models led by the Ministry are the Cancer Control Strategy and Healthy Eating-Healthy Action programme.

The Ministry could also be, and in some cases has begun, actively working:

- with the transport sector at a national level to assist in realising transport's public health objectives in the broadest possible way
- with the sustainable development teams to assist them with ways to include public health objectives in their quadruple bottom line reporting framework<sup>21</sup>
- to provide public health expertise to other agencies to assist in the assessment of their policies for their impact on health and health inequalities (Health Impact Assessment)
- with Housing New Zealand in the development of healthy housing standards and policies
- to provide public health guidance to local government through Local Government New Zealand.

At regional level, the Ministry of Health can support collaborative action by articulating the need for it in contracts with public health providers, and by providing opportunities to build skills and capacity for intersectoral action.

There are a number of existing structures at national level that facilitate communication between sectors. The Chief Executives of Health, Education, Social Development and Justice meet on a regular basis, as do senior social sector officials. These meetings have been important to the development of social reporting and related strategy (Opportunities for All), which provides a framework at a national level for all sectors to address the social wellbeing of New Zealanders, including a reporting schedule. Although the health indicators for this reporting are traditional health status measures, such as life expectancy, suicide, smoking and obesity, the programme also covers the major social,

<sup>20</sup> Based on New Zealand Influenza Pandemic Draft Action Plan, Version 14. Ministry of Health. 2005

<sup>21</sup> Social, cultural, economic and environmental reporting – all of which contribute to the health of the population as determinants of health.

economic and environmental determinants of health. This framework will likely have more authority across sectors than the New Zealand Health Strategy, which has most traction within the health sector.

## Relationships at a regional level

### *DHBs and PHUs*

The relationship between DHBs and PHUs, a key relationship in the public health sector, is still evolving and is variable across the country. PHAC investigations have shown rapid change in the quality of these relationships throughout the term of this project.

A public health approach is essential for DHBs to make the necessary shift in philosophical focus. In some DHBs this shift from operating only as a provider of tertiary hospital services towards taking a greater role to address health improvement, health inequalities and the wider determinants of health, has been a noticeable one. This increased commitment to public health is beginning to become evident in DHB Strategic Plans. For example, the Nelson-Marlborough DHB has committed more money to a Healthy Eating-Healthy Action initiative than its PHU receives from the Ministry for delivering public health services. This initiative will involve a range of other agencies – a truly inter-sectoral and community development model. The DHBs where the shift is occurring most strongly are those where the relationship with the Public Health Unit is close and collaborative.

Public Health Units have taken a key role in facilitating this DHB transition towards a population health approach, and those units with reporting structures close to their parent DHB are well-placed to do this. Public Health Units may be located on the planning and funding or service provision arms of the host DHB, or in the case of Community and Population Health in Canterbury, constitute a third arm reporting directly to the Chief Executive of the DHB.

In part this variance is due to the somewhat ambivalent role of PHUs. On the one hand, they have a separate contract with the Ministry of Health and therefore at arm's length from their DHB. On the other hand PHUs may have more strategic functions that suggest they are best located close to DHB planning structures.

The recent trend towards locating PHUs closer to the DHB in terms of reporting lines, has led to better coordination between DHB and PHU planning processes and more recognition of population health approaches in DHB planning documents.

When the PHU is placed close to the parent DHB, there is a potential for tension with the other DHBs to which the PHU provides services. However, the PHAC found that these tensions have so far been well addressed and that PHUs appear to manage good relationships with all of the DHBs to which they provide public health services.

Any potential for tension can be reduced with coordination and collaboration at a regional level, especially where one PHU works with more than one DHB. There are some models of coordination being trialled between DHBs and PHUs, and in some cases, with the Ministry of Health. For example:

## Auckland Public Health Coordination

The Ministry of Health and Auckland and Northland DHBs have recognised the need to provide collaborative planning and alignment of public health at a regional level. They have established collaborative groups at three levels:

- a Public Health Services Alignment Group consisting of the General Managers of Funding and Planning of the three DHBs (with Māori and Pacific representation), the Public Health Operations Group of the Ministry of Health, and a public health planner based in the Northern DHB Support Agency. This Alignment group focuses on aligning the Ministry's funding decisions and DHB priorities. A similar group involving the Northland DHB, Te Tai Tokerau MAPO and the Ministry, meets in Northland.
- a Public Health Services Planning Group consisting of DHB public health project managers, most of whom are public health physicians. This group puts planning proposals to the Alignment Group.
- a Stakeholder Forum for public health providers, which aims to give the provider view of public health planning and suggests how public health providers, particularly NGOs, should be working together and with other sectors such as local government. It will also transfer the learning of good collaborative practice.

The Hamilton locality office of the Ministry of Health has established public health positions in Lakes, Bay of Plenty and Waikato DHBs to assist DHBs to make the transition to include a focus on public health approaches. These posts also work with PHOs and agencies outside the health sector. The inclusion of public health expertise within the DHB planning and funding function is an important ingredient for the engagement of DHBs with public health approaches that will assist them to meet legislative responsibilities for the health of their populations.

In other regions, such as Nelson Marlborough and Canterbury, the Regional Public Health Manager has a strategic role to influence population health thinking at Board level. Nelson-Marlborough was the first DHB to bring the PHU into its Planning and Funding function and has been seen as a successful model throughout the country. However, another model is now being established in Nelson-Marlborough where the PHU will be separated from the DHB and combined with the regional co-ordination of primary health services. This is an attempt to put the promotion of health and prevention of disease on a par with personal health services.

Since their establishment, DHBs have had many structural issues to address and it is only now, when many of those have been sorted out, that they are able to look more closely at their philosophical direction. Although some DHBs appear not to have yet made the transition towards a strategic population health vision, during the life of the PHAC project there has been a significant shift in some DHBs towards approaches for health gain.

Conversely, some PHUs are thought by their DHB to be protective of their autonomy and as not seeing the importance of aligning their strategic planning with that of the DHB and working as part of a wider team. In the next contract negotiations, the Ministry of Health has decided to require PHUs to consult with their DHBs during the development of their service plans, to ensure they are aligned with DHB priorities as well as national priorities.

Those PHUs that still operate as provider arms tend to feel more isolated from the DHB, sometimes experiencing a conflict of roles between Planning and Funding and Public Health. By bringing public health reporting lines closer to the DHB, not only does the DHB gain from having improved access to strategic population health thinking, but the PHU may gain credibility with outside agencies.

**There is no 'one size fits all' structure. The key is an effective working relationship between the PHU and the DHB. It is essential that communication between the DHB and PHU is regular and of a high quality, with synchronised planning processes.**

Some of the variability of DHB commitment to a population health approach can be attributed to the fact that many DHBs, particularly the smaller ones, lack the capacity and resources to develop public health expertise on their own.

The level of DHB commitment may also be reflected in the makeup of the individual Boards and Community and Public Health Advisory Committees (CPHACs) where public health expertise tends to be under-represented. There is evidence to suggest that some CPHACs do not include public health issues in their principal focus. This could be remedied by ensuring public health expertise in Ministerial appointments to DHBs, and in DHB appointments to CPHACs.

In addition, Board commitment to public health approaches may be influenced by public health expertise at senior management level and in the inclusion of a strong public health commitment at planning and funding level.

**DHB and CPHAC appointments should include public health expertise and DHBs should include public health expertise at appropriate levels of the organisation to ensure DHB strategic direction is towards population health gain.**

Public health commitment by DHBs could also be enhanced by more clarity around the Ministry of Health's accountability requirements for the DHB public health role. Indications are that the performance indicators on which DHBs will be measured in the future will have a greater emphasis on public health than previously.

## **Local government and the public health sector**

Local Councils are well placed to see how the different sectors in their communities relate to one another. They have an interest in most activities that take place within their geographical boundaries, putting them in a good position to bring a range of stakeholders together to plan, provide and monitor community wellbeing outcomes.

New legislation has enhanced the opportunities for greater collaboration between local government and public health agencies.<sup>22</sup> The reforms require local authorities to work with their communities to identify community outcomes in terms of the social, economic, environmental and cultural wellbeing and to develop Long Term Council Community Plans (LTCCPs) that set out how the outcomes will be achieved. The four 'wellbeings' represent the four cornerstones of the sustainable development framework which underpins much of local government work. These four cornerstones of sustainable development also represent the wider determinants of health. This means that the core goals of DHBs and local government are aligned.

The community consultation process undertaken by local government to identify community outcomes encourages a climate of collaboration and partnership with key stakeholders including Māori/iwi organisations, community groups, government agencies, DHBs and other local authorities. DHBs and public health services have engaged local authorities through this process, often for the first time.

Most local authorities are finding that their communities are identifying health and wellbeing as a priority for them. This means that they are seeing opportunities to work more closely with the health sector as positive ways of meeting community needs, and linkages are beginning to emerge at both political and management levels. The Department of Internal Affairs is taking a lead role in facilitating and improving central government engagement in Community Outcome Processes.

**For opportunities for collaborative action to improve health and wellbeing to be realised, investment needs to be made to create sustainable partnerships between local government and the health sector, particularly with DHBs and PHUs.**

This can be achieved by a number of strategies including stronger political linkages between local Councils and DHBs; greater clarity about the public health roles of local government and the core public health sector; improving capacity and capability for collaboration; and public health support for local authorities to confidently undertake public health activities outside of their traditional role.

An example of a way to improve capacity and capability across sectors is through a jointly funded position. In Christchurch, Community and Public Health (CPH) and the Christchurch School of Medicine jointly fund a position to enable improved communication between research and practice. Another example in Christchurch is a post funded by Christchurch City Council and CPH to ensure that relevant Council policies are assessed for their potential impact on health and wellbeing (Health Impact Assessment).

Good communication is crucial and collaboration essential for effective use of resources. Both these qualities could be enhanced by secondments across sectors, by health-funded positions in local authorities, such as the Ministry of Health funded post at Auckland City Council, and vice versa, and by public health sector mentoring arrangements.

<sup>22</sup> Courtney M, 2004. The Future interface between public health and local government: a think piece for the Public Health Advisory Committee.

Communication would also be enhanced by use of common language. Currently many people in local authorities view 'public health' as being outside their responsibility, but are likely to engage when the same issues are couched in terms of 'community wellbeing'. It is up to the public health sector to seek entry points and levers for collaboration. This may mean using terminology strategically to engage other sectors.

In collecting information for this project, the PHAC has found much enthusiasm in the health and local government sectors for collaboration in various parts of the country. Public health sector input into the public consultation associated with community outcome processes is identified as a key entry point for the health sector, with community wellbeing and community safety being the public health levers.

Some local authorities are also seeking support from public health units for the assessment of council policies for their potential impact on health and wellbeing (Health Impact Assessment). This is an exciting development and has the potential to make a significant difference to the effects of council policies on population health and wellbeing. This is a new area of work for the health sector and skills development in Health Impact Assessment is urgently needed.

The committee has found public health knowledge of local government agencies to be variable. There is often a lack of public health and fiscal capacity, especially in the smaller territorial local authorities. The traditional approach to public health (provision of sanitation, water quality and food safety) still dominates local authority thinking. Some of the larger councils, where there may be more flexibility in the use of resources and more staff expertise, have taken a broader view of their mandate. They have been working on initiatives such as road safety, injury prevention, community and neighbourhood development, and poverty reduction strategies. Some have also been working across sectors on health issues affecting their communities, such as diabetes. A few have worked with public health staff on Health Impact Assessments.

There are many signs of public health involvement in local authority planning, largely associated with the identification of community outcomes through the requirement on local government. Developing relationships appear to be largely driven by the public health sector, although increasingly, local government is taking the lead on health issues affecting their populations. For example, Porirua City and Manukau City Councils have shown leadership in the collaborative effort to reduce and prevent diabetes in their communities.

Collaboration between local government and the public health sector is hampered to some extent by the variability and complexity of the number of relationships that need to be developed and sustained by Public Health Units, and the disjunction of boundaries and of planning processes. PHUs can have from between one and eleven local authorities to interact with, as well as several DHBs, numerous iwi providers and other NGOs. For example, Auckland Regional Public Health needs to sustain relationships with three DHBs, seven local authorities, one regional council, three Māori co-Purchasing Organisations (MAPOs) and about 20 PHOs, plus NGO providers and other sectors whose policies impact on health. Waikato DHB covers 10 territorial local authorities (TLAs) whereas Tairāwhiti and Nelson-Marlborough have just one and a single DHB. It is this variation in complexity of relationships that makes it impossible to design a 'one size fits all' model. **Interagency relationships need to develop differently in response to regional differences.**

Research conducted by McGrath (2005) which searched DHB and local government annual plans (2003-04) for evidence of intended collaboration, showed that DHBs are very aware of the importance of working with local government towards the common goal of community wellbeing. Conversely, there was little indication that local government put the same importance on the relationship. However, these results may have been skewed due to Ministry requirements for DHBs to include planning for collaboration with local government.<sup>23</sup> The research may also have been too early to capture advances made in collaborative arrangements. It would be of value to have this research repeated to identify trends over time.

In the UK there has been a strong call for boundary alignment between local and health authorities to facilitate greater collaboration in planning processes. In New Zealand, local authorities do not share geographical boundar-

<sup>23</sup> McGrath F. 2005. Do District Health Boards and Local Government collaborate? A research report supported by the Public Health Advisory Committee. Unpublished.

ies with those of DHBs. With three times as many local authorities as there are DHBs, changes to achieve boundary alignment would be great. Public health and tribal boundaries also differ. PHU boundaries are based on Health Districts under the Health Act 1956 rather than DHB districts under the NZ Public Health and Disability Act 2000. In addition, planning has been conducted independently and to different timeframes in local authorities and DHBs.

**There are clear benefits in synchronising DHB and local government planning cycles in order to facilitate collaborative work on common goals.** The Ministry of Health has indicated that the DHB strategic and annual planning cycles will be aligned to local authority Long Term Council Community Planning timeframes from 2007.

## Relationships at local level

### *Primary Health Organisations and DHBs/PHUs/NGOs*

One of the greatest changes at a local level is the establishment of Primary Health Organisations (PHOs) under the Primary Health Care Strategy. As already mentioned, PHOs, as well as delivering primary care services to individuals, are required to work with their communities to improve the health and wellbeing of their enrolled populations. Funding for primary health care is on a basis of the health needs of the populations they serve. PHOs represent a fundamental reshaping of the role of primary care in New Zealand' (Crampton 2004) and have great potential as partners in intersectoral action for improvement in health and wellbeing.

The Primary Health Care Strategy states the importance of clear linkages between primary care and public health. However, the population health role of PHOs is open to interpretation and there is still some uncertainty about the public health roles of PHOs relative to PHUs and NGOs. This may be because PHOs are still in the establishment phase, and like the early days of DHBs, are focusing more on the logistics of running their own services than collaborating with other public health providers to work out relative roles.

Much has been written about the potential synergies between public health action and primary care. There are many opportunities for primary care to influence people's health choices at an individual and family/whānau level. It is at this level where primary care services traditionally have pitched their health promotion activities – building personal skills and knowledge. However, there are also opportunities for PHOs to adopt a broader public health role; to address the wider determinants of health, particularly in collaboration with other health agencies and other sectors.<sup>18</sup>

The Ministry of Health has published the 'Guide to developing health promotion programmes in primary care settings' which describes PHOs as being 'complementary' to the health promotion programmes already provided by PHUs and NGOs. This implies a strong need for all three to work together with their DHBs in a coordinated way to ensure there are common goals and collective action but not duplication of effort.

Theoretically, PHOs should bring an increased potential for collaboration and a general enhancement of public health activities. At local level, much of the public health sector acknowledges, and is taking advantage of, the opportunities for increased collaboration. However, there are considerable challenges. While there are opportunities for PHOs to work with others inside and outside the public health sector, many PHOs have need for significant professional development in population health approaches, to facilitate the paradigmatic shift from biomedical towards public health engagement. Taking advantage of new opportunities requires new ways of thinking, for PHOs and for the traditional public health sector.

The public health sector has a clear role in supporting PHOs to make this shift and to effectively engage with other public health players. The Ministry of Health funds PHUs to support PHOs in the development of their health promotion capacity and expertise. This funding is currently being used primarily to support the development of PHO health promotion plans. In addition, the Ministry has established some DHB positions in the Waikato – Bay of Plenty region to provide this support (see also pg 25). A closer relationship between public health and primary health services has a potential for mutual benefit and increased engagement across the sectors.

There appear to be connections between the successful linking of primary health with population health approaches, and the community-based culture of some PHOs. Those that have a history of community development and population health approaches are more likely to work collaboratively. Examples include Porirua Healthcare Plus and other similar PHOs, and the Māori-led PHOs. This history puts them in a better position to undertake effective health pro-

motion in their communities, compared with PHOs that have a traditional bio-medical primary care history.

### *Non Government Organisations*

NGOs have a history of collaboration with other sectors and with other players within the sector, an approach strongly endorsed by the Ottawa Charter for Health Promotion and the recent Bangkok Charter. NGOs have long been involved in intersectoral initiatives such as Healthy Cities/ Healthy Communities, and many have taken leadership roles. The changing public health environment has created new opportunities for new collaborative work. For example, the National Heart Foundation has established a partnership with some PHOs to assist in the delivery of their health promotion programmes.

However, it appears that so far, PHOs have offered limited response to NGO attempts to form relationships, probably because they are still in the early stages of development.<sup>24</sup> It is important that the relationship is monitored over time, to ensure that both DHBs and PHOs value the work of NGOs enough to form collaborative relationships with them. There is a leadership role for the Ministry of Health to provide some clarity in relation to the inclusion of NGOs in both the primary and public health sectors.

NGOs at a local level tend to be strongly in touch with their communities and therefore are well-placed for community development approaches to improving health and reducing inequalities. This is particularly true of Māori/iwi and Pacific providers who work to not only support whānau/fanau but also to influence community leaders.

Although NGOs represent a significant part of the public health sector, there is a perception that there is a lack of clarity about how NGOs fit in the rest of the sector, particularly in relation to PHOs. This is an issue with funding bodies such as the Ministry of Health, which need an overview of how the sector fits together.

NGOs have a rich experience that DHB strategic planning could be harnessing more frequently. NGOs, including Māori/iwi and Pacific providers, are often left out of the strategic planning processes until the planning is well-advanced. The Ministry of Health has established an NGO provider forum that provides advice to the Ministry on issues affecting NGOs, including public health NGOs. DHBs could establish similar forums in the regions as have been established in Auckland and Northland (See pg 25).

### **Relationships for collaboration across sectors**

Because of the number of different players which have an influence on the health and wellbeing of the community, it is essential that effective networks, alliances and partnerships are developed to aid communication and collaboration. There are many opportunities for effective collective action in the current public health environment, but there are also some challenges that may limit those opportunities. This section showcases some good collaborative models.

#### *Examples of effective collaboration*

Some examples of effective regional networking and partnerships in New Zealand are shown below. See also the pandemic planning example in the previous chapter.

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<sup>24</sup> Health and Disability Sector NGO Working Group. 2005. NGOs and the Primary Health Care Strategy.

## Healthy Eating, Healthy Action <sup>25</sup>

A model for intersectoral collaboration at national and local levels:

A number of risk factors may be common to a number of preventable chronic conditions. For example, poor nutrition and low levels of physical activity are risk factors for preventable conditions such as cardiovascular disease, diabetes, cancer and obesity.

The Healthy Eating, Healthy Action (HEHA) Strategy was developed by the Ministry of Health to improve nutrition and increase levels of physical activity across the population to reduce the risk of people developing these conditions.

The implementation plan (the plan) for the strategy provides a good interagency collaborative model where the Ministry of Health and Sport and Recreation New Zealand (SPARC) provide national coordination and leadership, with DHBs and PHOs being key agencies at a local level. An external reference group includes a wide range of stakeholders.

The plan not only forms the basis for purchasing in the health sector but fosters collaboration and coordination across sectors. It recognises that the health sector alone cannot produce the outcomes the strategy expects and that it will need to involve a wide range of government, non-government and business sectors. The plan specifically names education, sport and recreation, local government, social development, transport, NGOs and the food and physical activity industries, all of which contributed to the plan's development in some way.

The Ministry will monitor progress on the plan. Some outcomes already include the Food Industry Accord<sup>26</sup> which comprises food producers, manufacturers, retailers, advertisers and media organisations; social marketing plans by the Health Sponsorship Council; and DHB responses, including significant DHB investment in action at a regional level, for example, \$10 million by Nelson-Marlborough DHB over five years.

<sup>25</sup> Ministry of Health. Healthy Eating – Healthy Action: orange Pumau: Implementation Plan 2004-2010.

<sup>26</sup> The Food Industry Accord in New Zealand is a different model of intersectoral collaboration in that it includes sectors that have not traditionally worked with the health sector, such as food producers, manufacturers, retailers, advertisers, and marketers such as media organisations and publishers. It is too early to say if this model will be effective in addressing causes of obesity.

## Healthy Cities in New Zealand

The Healthy Cities movement is a World Health Organization initiative that is based on collaboration across sectors for health improvement. It is based on the Ottawa Charter principles and recognises the importance of local government in fostering good health.

### *Healthy Christchurch*

Healthy Christchurch is one New Zealand's best examples of a healthy cities model. It has over 200 signatories to the Healthy Cities Charter and has top-level support from key agencies in Christchurch – Canterbury DHB, Christchurch City Council, Te Rununga o Ngai Tahu, Community and Public Health, Pegasus Health, Christchurch School of Medicine and the Ministry of Health.

Intersectoral project groups are established to work on specific issues such as Healthy Workplaces, Healthy Homes, Oral Health, Māori employment, sustainable livelihoods etc.

### *Te Ora o Manukau – Manukau the healthy city*

Te Ora o Manukau initiative was first launched in 1989 with fifteen signatories. The third charter was signed 10 years later with 49 signatories. The Charter vision states:

*We are committed to quality of life and well-being for all Manukau people and to Te Tiriti o Waitangi. We undertake to work in partnership, to share our resources, and to co-operate. Holding the vision 'Health for all', we strongly advocate full participation of our staff and volunteers towards this goal."*

Action plans have been developed focusing on particular issues such as child poverty. They identify specific objectives, actions and which agency would take the lead. Many organisations and agencies have made a commitment.

### *Sustainable Cities*

The Auckland Sustainable Cities Programme is a regional partnership with the Sustainable Development Programme of Action. It is a three-year partnership from 2003-06 involving the region's seven local councils, the regional council, the Auckland Regional Public Health Service and a number of government agencies. Communities are also participating in many parts of the programme. Desired outcomes for Sustainable Cities are:

- Cities as centres of innovation and economic growth
- Liveable cities that support social wellbeing, quality of life and cultural identities.

Work strands cover transport, urban design, child and youth health, regional settlement, sustainable communities and economic development.

## Healthy Housing

The Healthy Housing Programme is a collaborative programme to reduce health problems related to housing conditions. The programme aims to reduce over-crowding, improve housing conditions, improve access to primary health services and facilities, and raise community awareness about the relationship between good health and good housing.

The Healthy Housing Programme was established four years ago and won the supreme 2005 Health Innovation Award. Partners in the programme are Counties-Manukau DHB, Auckland and Northland DHBs, Housing NZ Corporation, and Auckland Regional Public Health Service.

After priority sites have been identified, a public health nurse and a tenancy manager carry out a joint onsite visit. The public health nurse assesses the health and well-being of the family, linking them to health and social services. The tenancy manager assesses the family's housing needs, facilitating improvements such as insulation and ventilation.

Evaluation of the Healthy Housing pilot suggests it increased the seeking of early health care, with a resulting decrease in hospital admissions. The largest increases in primary care visits were for immunisation and diabetes care (55 per cent increases), and skin infections (41 per cent increase). The largest decreases in hospital admissions were for pharyngitis (down 22 per cent) and middle ear infection (down 15 per cent).

Other examples of effective cross sectoral collaboration are:

- *Health Promoting Schools* – a collaboration between the health and education sectors to provide a health-supporting school environment. The strategy has been developed at national level but is implemented at local level.
- *Strengthening Families* – a case management collaboration across a range of government agencies to improve the overall wellbeing of families considered to be “at risk”. It includes Family Start, an early intervention programme for children. Again, there is local implementation of a national strategy.

In the PHAC investigations for this and other projects, the committee has found high levels of collaborative activity at regional and local levels, particularly in rural areas. Rural regions the committee has visited over the course of the project include Te Tai Tokerau/Northland, the West Coast of the South Island, Wairarapa, and Tairāwhiti/Gisborne, all of which have innovative examples of collaboration for health improvement. For example:

- *Kori Kori a Iwi* – all five iwi providers in Te Tai Tokerau collaborate to increase physical activity and improve nutrition across the Māori population. They work with agencies such as sports clubs, schools, polytechnics, marae and Māori development organisations
- *Ngati and Healthy* – an action research project led by Ngati Porou Hauora has involved many sectors within the community in its research on community interventions that reduce insulin resistance amongst the East Coast Community
- *Healthy Inangahua* – a project on the West Coast was developed as a community-led process involving a wide variety of organisations, with Community and Public Health (CPH) providing the initial idea and funding to support the project and resulting developments. CPH sees its role in the area as one of coordination, facilitation and support of other sectors.

Collaborative action to address the wider determinants of health and wellbeing requires new ways of thinking beyond the boundaries in which the health and other sectors have traditionally worked. New skills are needed at both an organisational and individual level and strategies for building capability across all levels.

# CHAPTER 4: BUILDING CAPABILITY FOR COLLABORATIVE ACTION

**New settings for public health action, new imperatives for collaboration, the need for new relationships, and a rapidly changing environment for public health, highlight the need to explore ways to build capability for effective public health action for the future.**

This chapter outlines the capability needs of organisations and their workforce for effective and collaborative public health action.

## Organisational capability

New opportunities for collaborative action are presenting themselves in an environment of changing roles and responsibilities, and new players in public health. Roles and responsibilities can now be redefined in terms of how they fit with the roles and responsibilities of other agencies/organisations, and in terms of where opportunities exist for collaborative action. For example, the Local Government Act 2002 has given local government the potential to be more involved in public health action.

However, this does not mean that local governments will necessarily have the capability or capacity to respond to these opportunities. It is important that guidance is given on how this potential to be more involved can be developed in a collaborative context. Similarly for the establishment of PHOs with a population health focus, and for CPHACs, opportunities exist to describe their new roles in a context of working together.

Building organisational capability for collaborative and effective public health action is dependent upon organisations having defined goals, a clear sense of their roles and responsibilities, and an understanding of their relationships with others. One option for achieving this would be the development of a national vision for how different structures fit together in a strategic sense. This would involve the identification of public health functions, associated organisational competences required for these functions, and the matching of these competences to different organisations. This could be a useful exercise, but there is a risk that in prescribing specific organisational roles the advantages of collaboration and flexibility would be lost. There is a need for sustainable flexibility in the renegotiation of roles as situations and priorities change.

The World Health Organization and many individual countries are developing lists of essential public health functions. Although discussions have been limited in this country, New Zealand has endorsed the WHO Western Pacific Region's recommendation to develop essential public health functions at regional (ie, Western Pacific), country, provincial and programme levels, in order to strengthen public health action.<sup>27</sup> These functions tend to be more relevant to the core public health sector than to other agencies. Any list that was developed for New Zealand would need to be developed collaboratively across sectors.

<sup>27</sup> McCracken H. 2004. Essential public health functions: Carpe diem time for New Zealand? A think piece prepared for the Ministry of Health.

## Workforce capability

The public health workforce is diverse and complex, covering the many disciplines and functions required for public health action, and existing in many different agencies and organisations. The workforce includes public health physicians, planners, policy analysts, health promoters, health protection officers, community development workers, epidemiologists, researchers, and public health nurses, all with diverse training and educational needs. They cover a huge range of functions including monitoring and surveillance, planning and funding, regulation and enforcement, community development, policy development, social marketing, and management and administrative support roles.

**The skills required to develop strategic approaches to the determinants of health, for brokering and catalysing interagency work and for evaluating programmes, are different from those required for fulfilling contractual obligations in more traditional public health action areas.**

Although the public health workforce is highly skilled and committed, there is a skills deficit in these new approaches that needs addressing, and is being addressed by the Ministry of Health.

## Workforce competences

The Ministry of Health has developed a Public Health Workforce Action Plan to address the lack of a strategic and coordinated approach to workforce development. The PHAC strongly endorses this initiative and looks forward to further opportunities to discuss its implementation. It is important that the plan is supported at all levels of public health action and across a wide variety of relevant organisations.

To inform the Action Plan, the Ministry of Health commissioned a survey to identify who is working in public health, what they are doing, what skills and training they have, and what they may need. Although focused primarily on the public health sector with Ministry of Health contracts, the research report acknowledges the need to strengthen the capacity and competency of the wider sector.<sup>28</sup>

A skills deficit in the public health workforce was identified by this research and by the PHAC investigations. This skills deficit is largely focused around the new organisational and professional roles associated with new approaches to public health like intersectoral collaboration, but also includes recruitment and retention issues, especially in smaller provincial areas.

In addition to the traditional issues-based public health action required by contracts with the Ministry of Health, public health practitioners may now be called on to support PHOs in developing their public health programmes, and to support local government to assess their policies for potential impacts on health. They are required to make submissions on a range of factors that impact on health such as urban development and Regional Land Transport Strategies, to influence policy in favour of health and wellbeing.

These new ways of working demand additional individual skills and organisational capabilities to those required by the traditional public health roles. Opportunities need to be available for practitioners to extend their range of skills to become confident in these areas.

Implementation of the Public Health Workforce Plan requires the development of core competences for the public health workforce. New or increased roles in public health for some agencies require a set of competences that may be lacking, for example in PHOs and territorial authorities, but also in core public health organisations. Organisations that have taken on new public health roles, such as PHOs, may have their skills needs identified by the development of core competences, but increased roles, such as those required for intersectoral work on the wider determinants of health, may require skills outside of the core competences. It is important that both core competences and those additional skills required by new public health approaches are identified.

Cultural competences need to be valued along with tertiary qualifications for public health action. For example, tikanga Māori should be valued as key expertise for public health practitioners employed to work with Māori and for the public health workforce in general. In addition, there needs to be an agreed skill set to address the population health needs of Māori and Pacific people, and to tackle health inequalities generally.

<sup>28</sup> Phoenix Research. 2003/2004. Public health workforce development research. A research report for Head Strategic (on behalf of the Ministry of Health)

## Workforce development

Within public health there is a general lack of opportunity for professional development and unevenness across the country in accessibility to skills development programmes. Most workforce development takes place within occupations, which means that there is considerable variability across occupational groupings. There need to be more opportunities to develop new competences and to establish clear pathways for the professional development of many public health roles, not only within occupational groups but also across them.

The UK Faculty of Public Health Medicine changed in 1993 to the UK Faculty of Public Health. It has extended its focus on medically trained public health practitioners, to recognise the multidisciplinary nature of the public health workforce, by developing pathways and common assessment frameworks across all occupations in the sector. A set of national standards for public health has been developed in the UK as a necessary stage in building capacity and capability of the public health workforce.<sup>29</sup> These standards provide a coherent overview of public health and a shared language for collaboration. A similar initiative could be taken in New Zealand as a quality basis for the development of core public health competences under the Public Health Workforce Development Plan.

There are few formal mechanisms in New Zealand for a collaborative approach between the tertiary education sector and the public health sector to plan for workforce development needs. Tertiary institutions provide opportunities for formal qualifications in public health but in the main do not see themselves as offering occupational training, which has traditionally been provided in the workplace. However, there needs to be a collaborative approach and there are signs that tertiary providers and the public health sector are building closer relationships.

Although the Māori public health workforce stands at around thirty percent of the total, Māori are under represented in senior and better paid public health positions and in regulatory roles. This means that Māori are not well represented at the decision-making levels of public health organisations. It also means that Māori public health workforce development needs to be a priority to ensure increased Māori input into decision-making processes. The Ministry of Health workforce development framework has addressed issues for Māori and will progress them. Leadership training programmes have been developed for Māori public health workers in the Midlands region and in Auckland.

The Pacific public health workforce is very small. The Ministry workforce development plan suggests the need for a more in-depth Pacific public health workforce needs assessment and coordination of Pacific training initiatives. This needs assessment would most likely identify the need to further develop Pacific workforce capacity and capability.

## Funding arrangements

**Funding arrangements may facilitate or limit the opportunities for collaborative approaches to public health action.**

Currently, most public health services (in the core public health sector) are funded by the Ministry of Health, having contractual arrangements with Public Health Units, and directly with NGOs and other local public health providers. A few NGOs are funded directly by DHBs and may also receive local funding from a variety of other agencies. PHUs may have contracts with other agencies such as the New Zealand Food Safety Authority and National Screening Unit.

### Ministry of Health contracts

Public health service delivery by Public Health Units and other providers is governed by a principal contract with the Ministry of Health. Purchasing by the Ministry for public health services has been governed by public health priorities as listed in the Public Health Service Handbook, which, as previously described is programme based and output focused. This Handbook has not kept pace with the paradigm shift that has occurred in public health action resulting in a mismatch between the contracts and actual public health action. Although the Ministry negotiates Service Plans with its providers that move beyond the programme based priorities as listed in the Handbook, it is important that the Handbook is either reviewed regularly to ensure that it reflects broad strategic public health priorities or that it is replaced with another system.

<sup>29</sup> Skills for Health. 2004. *Guide to the National Occupational Standards in Public Health Practice*.

The PHAC believes that funding arrangements need to provide additional opportunities for:

- developing and evaluating innovative strategic approaches to population health goals
- brokerage for intersectoral collaboration on the social, economic, cultural and environmental determinants of health and wellbeing, and on healthy public policy
- settings-based approaches (eg, Healthy Communities, urban environments, workplaces, Marae etc)
- professional development and organisational infrastructure
- engaging and empowering communities for action for health improvement
- an outcomes focus.

Until a decision is made regarding whether the Handbook is replaced or revised, it remains the lynch pin of contractual relationships with the Ministry and its public health providers. However, new three-year contracts are currently being negotiated to begin in the 2006/07 year and providers are being encouraged to indicate future direction for public health action in their service plans. Some PHUs have already signalled their intention to move more towards an outcomes focus and settings-based approaches in their next three year service plan. This shift is being negotiated with the Ministry and is PHU led.

### Local priorities and Ministry contracts

**Public health planning must have relevance to DHB priorities, not only for the parent DHB but for all the DHBs for which a PHU provides services.**

Because the public health contract is with the Ministry of Health, there is potential for tension between the Minister's priorities as specified by the contracts with the Ministry, and local priorities as identified by the DHBs. Some regions have established 'steering groups' comprising senior management from the Ministry, the DHBs and the PHU to ensure alignment between national and local planning priorities eg, Auckland (see Chapter 3) and Wellington. The PHAC recommends that such steering groups are established in other areas, especially in regions where the PHU serves more than one DHB.

In the current round of contract negotiations, the Ministry is requiring the PHU to consult with its DHBs to ensure some synchronicity. The PHAC strongly supports this move, which it believes will address the planning anomaly that has previously existed. The committee would also support the monitoring of DHB Strategic and District Annual Plans for genuine engagement with health gain and other key public health goals.

### NGOs

National NGOs are funded directly from the Ministry of Health and may be based on a single issue such as tobacco control, or on wider public health issues (such as for the Public Health Association and the Health Promotion Forum). Local organisations that do not distinguish between personal health, public health and social wellbeing, such as Māori/iwi providers, may have a range of contracts with DHBs and other local funders such as social services.

**When a new area of work is identified, it is important that the ability of existing organisations to incorporate new functions is considered, rather than simply establishing new organisations to take on the work.**

Existing NGOs, should be considered for their capacity and capability for additional work. NGOs on the whole, tend to provide more for their money because of their commitment to addressing needs over and above their contractual requirements. This needs to be recognised when considering potential providers.

### Funding models

**The relationship between public health providers and the funder needs to balance the legitimate need for accountability with the flexibility to respond to emerging issues in innovative ways.**

Funding models can be placed along a continuum from maximal specification of purchased services at one end, to minimal specification of services at the other (a grants based approach). At the grants end of the continuum the contractor is recognised as holding the expertise, and the relationship assumes a strong element of trust and flexibility. The contracts based approach, with a highly specified service schedule, assumes that the expertise is with the purchaser and includes a strong accountability element.

The Ministry has developed a contract-based approach with strong accountability requirements, but which allows for some negotiation around the development of the service plan, which states how the services will be delivered and measured. Its contracting with NGOs is based on Treasury Guidelines and is output focused.<sup>30</sup>

It is important that the contracting relationship is flexible enough to allow for emerging and innovative work. Other funding models should be explored if this flexibility is not adequate in the current contracting environment. An ideal model would be a partnership relationship between funder and provider based on a relationship of negotiation and trust.

Currently contracting arrangements for public health are separate from personal health services. This does not reflect the holistic approaches of many community-based services such as those provided by Māori and Pacific health providers who see public and personal health as interdependent. The current issue-based contract model of funding does not fit well with Māori and Pacific concepts of health. An iwi provider, for example, may have a contract to provide a single public health service, but a visit to a household may identify a whole raft of personal health and social issues that need attention.

## Funding for action across sectors

The government's 'Review of the Centre'<sup>31</sup> has resulted in the potential for more flexibility for funding across government departments at a national level. This flexibility also needs to be reflected at regional level, giving the potential for innovative intersectoral ways of addressing local public health priorities. Craig (2004) has identified the "need to create a better environment for local collaboration by being much clearer about the mandates that are to be managed locally and lining these up with appropriate funding and (shared) accountability structures".<sup>32</sup>

The availability and flexibility of resources to support collaborative action is particularly important in addressing Māori public health, because Māori providers and organisations generally work collaboratively, both with each other and with other sectors. In Northland, all five iwi providers, which theoretically could be in competition for funding, have collaborated on increasing physical activity and improving nutrition in the Māori community. In addition, an iwi provider has a partnership with the Northland Polytechnic to provide a QA certificated course in traditional Māori activities. Collaborative approaches are also used effectively in the Pacific community.

If funding is not flexible enough, innovation may be stifled. In Tairāwhiti, the 'Ngati and Healthy' project led by Ngati Porou Hauora has involved many sectors within the community in its research to reduce insulin resistance amongst the East Coast community. This community action research project met with funding difficulties because it did not fit the Health Research Council /Ministry of Health funding parameters and there are no funding pools for this type of innovative project. Due to local dedication, Ngati and Healthy went ahead anyway with a reduced budget and reliance on much voluntary input.

More funding pools for innovative projects that fall outside of contractual arrangements should be available. A good model for this is the Healthy Eating, Healthy Action (HEHA) Initiatives Fund, which encourages DHBs and PHOs, as partners, to apply for funding for innovative public health initiatives that are consistent with the HEHA Implementation Plan. Taking this one step further would be to extend the partnerships to sectors outside the health sector. The PHAC acknowledges the complexities and administrative difficulties in cross sectoral funding arrangements.

## Accountability and monitoring

**Contractual accountability and monitoring arrangements are important and should be flexible enough to encourage innovation.**

Currently accountability for Ministry contracts appears quite rigid hampering investment in joint initiatives that

<sup>30</sup> New Zealand Treasury. 2002. *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown*. Reviewed in September 2003.

<sup>31</sup> *Report of the Advisory Group on the Review of the Centre*. A report to the Ministers of State Services and Finance. November 2001.

<sup>32</sup> Craig D. 2004. Building better contexts for partnership and sustainable local collaboration: A review of core issues, with lessons from the "Waitakere Way". *Social Policy Jol. of NZ*. Issue 23.

clearly have significant impact on health, such as healthy housing. In addition, contract monitoring of settings based approaches to public health action (for example working with schools, Marae, Healthy Communities, supermarkets, workplaces) are acknowledged as effective approaches, but contractual monitoring is difficult because of the programme based nature of the contracts.

## Monitoring health status

The monitoring of health status across the population is largely undertaken by the Ministry of Health's business unit, Public Health Intelligence. This unit has the Ministry of Health's statutory responsibility to monitor the health of the New Zealand population by analysing health outcomes, risks and determinants. It measures how healthy the New Zealand population is over time and examines inequalities in health across regional boundaries and between various population groups. It monitors health status across DHB regions and can compare one with another.

However, there is no clear responsibility for monitoring the health of the population at local level. DHBs, local government and PHOs all are required to improve the health or wellbeing of their communities but with no clear lines of accountability for the monitoring required to measure progress.

## Managing information

Public health action is evidence-based wherever possible, and as such requires access to relevant information about populations. Effective collaborative action requires agencies to collect and share information. New technologies have provided increased opportunities for the effective collection, management and sharing of information. Public health action needs to find ways to take advantage of these new technologies in order to improve opportunities for collaborative effort. Not all of the expertise needed to take advantage of the opportunities provided by new technologies will be held at local level.

**It is therefore imperative that central leadership is provided along with descriptive statistics and frameworks for collecting information, to ensure consistency across DHB regions and to build up a national picture.**

For collaborative relationships to be fully effective, they need to be based on ways to share information between organisations. At a local level, health information is held by DHBs, local governments, individual health providers and others. Individual agencies are constantly improving ways of collecting, managing and using their own information to monitor the health of populations. There are however, many lost opportunities to share information across agencies at a local level, mainly through lack of knowledge of what information exists, but also through perceived issues of privacy or trust.

The New Zealand government's 'e-government strategy'<sup>33</sup> has been developed to aid such government policies as 'Managing for Outcomes'<sup>34</sup>, to help focus the public sector activity on people and communities, and to assist in building public sector capability. The e-strategy states a clear need for agencies to work more effectively across their traditional boundaries and collaborate with other agencies, stakeholders and their customers.<sup>33</sup>

The Ministry of Health has developed a Health Information Strategy that builds on previous strategies and on the WAVE project (Working to Add Value to E-information, 2001<sup>35</sup>). The Strategy aims to provide a framework for the provision of integrated information systems throughout the sector. Implementation of the strategy expects to connect community providers to a secure health information network and make "relevant key event summaries" accessible on line. It will ensure that funders and providers will have information about the health status of their populations and that information systems will be more aligned to strategic priorities.

However, this Strategy focuses on the access to information that will inform the delivery of health care. It will facilitate sharing of information and collaboration between primary and secondary health care providers such as hospitals, PHOs, pharmacies, diagnostic services etc.

<sup>33</sup> New Zealand Government. 2003. E-government Strategy. Accessed on line at <http://e.govt.nz/about-egovt/strategy> on 13 March 2006.

<sup>34</sup> Managing for Outcomes aims to improve results for people by refocusing central government planning to achieve results, as well as deliver outputs.

<sup>35</sup> The WAVE report produced findings of a survey of the current state of health information management in New Zealand in 2001.

**It is important that implementation of the Strategy ensures the development of information systems that also inform public health practice and facilitate the sharing of information both within the sector and with other sectors.**

Public Health Intelligence has established PHI On-line (under development), a website that gives mapped information about health status across the population and regional differences. There are also many other sources of information such as Statistics New Zealand, the New Zealand Health Information Service, universities, the Ministry of Health and Ministry of Social Development.

Some Public Health Units have established their own Public Health Intelligence Units to provide information at a local level. They access information from a variety of local sources including aggregated data on such factors as ethnicity and smoking status. There are problems in accessing clinical information held in secure environments to inform public health action, for example from PHOs, but there is advantage in being able to collate and hold local information. The establishment of individual, regionally based public health intelligence units provides an important resource for regional public health action and for learning about the effectiveness of particular interventions undertaken at the regional level. To facilitate learning across regions and to allow national co-ordination it is important that common frameworks for data collection and monitoring are used.



## CHAPTER 5: LEADERSHIP FOR COLLECTIVE ACTION

**Health improvement across a population requires the individual and collective efforts of a range of agencies and organisations. This raises the question of who leads and coordinates that effort.**

The capacity of any single sector to improve the health of the population and reduce disparities is limited. However, there are key roles and opportunities for the core public health sector to lead effective collaboration across sectors.<sup>36</sup>

Leadership can take a number of forms – individual, organisational or community-led. It can exist on a number of levels – national, regional and local. Professor Mason Durie in his Te Pae Mahutonga model talks about five different forms of leadership – community, health, tribal, communication and alliances between leaders and groups.

Leadership can facilitate action through other organisations and structures or dictate action through the authority of legislation and regulation. Different forms of leadership will be appropriate in public health according to the issue being addressed. For example, response to public health emergencies requires authority, an almost military style of command and control. Conversely many non-regulatory activities such as community action will require leadership to maximise opportunities for consensus and participation.

### Central leadership

There are two essential components of central leadership – executive leadership from central government and leadership from public sector bureaucracies.

#### Executive leadership

While regional public health agencies can initiate collaborative action at the regional, district and local levels, the Cabinet provides the ‘whole of government’ leadership to ensure all government agencies aim to protect and promote community health and wellbeing, and reduce health disparities. Some authors have used the term ‘public health policy’ to describe this approach to public administration, not to be confused with ‘health care policy’. (Hunter 2003, Gauld 2004).

Cabinet can lead by example, with collaborative effort at this executive level to enshrine the promotion and protection of health and wellbeing into legislation and overarching policies. Recent examples of this have resulted in public health objectives being included in transport and local government legislation, and in the development of the cross governmental strategy, ‘Opportunities for All’, promoting population wellbeing across sectors. These initiatives are supported by the government’s ‘managing for outcomes’ policy, which seeks to reduce fragmentation and increase opportunities for interagency collaboration around common long-term policy outcomes.

Cabinet can also ensure that assessment of the potential health and wellbeing impacts of significant policies are routinely incorporated into policy development in all sectors (Health Impact Assessment). It can require that government departments and ministries take into account the health consequences of their actions. Incorporating issues of

<sup>36</sup> Gauld R. 2004. Public Health and government in New Zealand: Discussion paper for the Public Health Advisory Committee.

health gain into the criteria that ‘control agencies’ such as State Services Commission, Treasury and Auditor-General, use in their assessment of government departments would be one way of ensuring this. Cabinet can make the links between public health and other whole of government responses such as sustainable development and economic development.

Cabinet leadership needs to be supported by a public sector with the necessary expertise. Currently the Ministry of Health’s Public Health Directorate provides public health expertise to Cabinet through the Minister of Health, who also receives some public health advice from the PHAC. Given that sectors across government have significant influences on the health of the population, public health expertise provided to Cabinet should have a strong ‘whole of government’ component.

## Public sector leadership

As previously described, public health leadership at a national level must involve capacity for both consultative and more directive command and control approaches as appropriate. It must also provide an overall vision for public health in New Zealand and strategic leadership on key issues and strategies and technical capacity to advise all sectors on a range of public health issues.

Authoritative leadership is required for dealing with national emergencies. There need to be transparent lines of authority that are clearly communicated to ensure that roles and responsibilities at national, regional and local levels are obvious.

Even in such scenarios, collaboration across sectors is essential, especially at the planning stages for national emergencies. Pandemic planning has effectively modelled this collaboration at a national level, led and coordinated by the Ministry of Health. It is important that effective communication through to regions and districts ensures that this collaborative model is reflected at regional and district levels.

Other public health matters are likely to require more consultative and consensual leadership, but still with strategic direction provided by the Ministry. For example, leadership for the implementation of the Healthy Eating, Healthy Action (HEHA) Strategy to improve nutrition and increase physical activity in the population, requires the facilitation of collaboration between sectors. The Ministry of Health has established an external coordination group to facilitate information sharing, coordinate activities and to oversee progress on the HEHA Implementation Plan. This group has engaged a wide variety of stakeholders including representatives of central government agencies, local government, DHBs, relevant NGOs, marketing and broadcasting industry, and the food and fitness industries. It is an intersectoral model with much potential.

Collaborative leadership at a national level can be strengthened by

- developing sustainable relationships across sectors
- brokering public health ideas across sectors, including the wider determinants of health
- bringing sectors together for collaborative effort
- promoting the use of health impact assessment, particularly of significant high level policies, to other sectors and more generally requiring the acceptance by agencies outside the health sector of responsibility for health related outcomes of their actions.

In addition to providing advice to the Minister and leading collaborative action at a central level, the Ministry of Health is well positioned to look ahead to identify emerging trends and provide strong strategic guidance to DHBs and PHUs on how to address them.

It should also be a repository of strategic information, collecting and comparing data, and providing benchmarks, surveillance and standardisation. (This role is undertaken by the Public Health Intelligence Unit of the Ministry of Health). It must also have the capacity to advise on a range of technical issues.

## Regional and Local Leadership

**At a regional level, District Health Boards, with their Public Health Units, are currently the agencies best placed to coordinate and broker public health responses across agencies. For effective public health leadership, it is**

**critical to create positive relationships between DHBs, Public Health Units and other local and regional agencies.**

### **Leadership - District Health Boards and Public Health Units**

Historically, local health authorities have had a major focus on healthcare service delivery and have not given priority to leadership on key public health issues. In the early days of DHB establishment, this was still the case. However, although there is considerable variation across the country, some DHBs are now finding that public health perspectives are assisting them to move from a 'hospital board' culture towards the wider role expected of a DHB, with health improvement of their populations as a priority.

There is great variability of engagement of DHBs with public health goals and action. There appears to be a relationship between level of commitment to public health and the individual makeup of its Board and Community and Public Health Advisory Committees (CPHACs).

During its consultation process, the PHAC found that those DHBs where there is public health commitment by Board members and/or senior management also demonstrate a greater engagement with public health approaches in the overall direction of the DHB. Many innovative examples of collaborative public health leadership occur locally. But relationships can be very complex and are still settling after significant changes to public health structures and functions at this level.

**Public health expertise needs to be more strongly represented in DHB offices, in Board appointments, and in appointment to CPHACs.**

### **Leadership - local government and the core public health sector**

The relationship between local government and the rest of the public health sector is still developing and early indications are that collaborative effort is being driven largely by Public Health Units (PHUs). However, DHBs are increasingly likely to have ongoing relationships with local authorities at both governance and management levels. For example, in the Hutt Valley, the Mayor of Hutt City sits on the DHB Board, and a high level intersectoral forum has been established that includes the DHB Chair and Chief Executive, the Manager of Planning and Funding, and the Mayor and Chief Executive of Hutt City.

However, DHB leadership at this level is still evolving and is variable across the country. It is important that where it exists, a similar relationship needs to be developed between the staff of the DHB and local government before collective action will occur.

As previously mentioned, Public Health Units throughout the country are taking leadership opportunities presented by the community consultation processes associated with the requirement of the Local Government Act 2000 to develop Long Term Council Community Plans (LTCCPs). They are also taking leadership roles in Healthy/Sustainable Cities initiatives, Regional Land Transport Strategies, urban design policies, and other local government planning processes. Local authorities are now consequently showing increasing interest in engaging PHUs to assist in assessing policies for their impact on health.

## Health Impact Assessment.

Auckland Regional Public Health has taken the lead to engage the Auckland City Council in carrying out a Health Impact Assessment (HIA) on the Avondale Liveable Communities Plan, which seeks to fit an additional 2000 households into Avondale over the next twenty years. The HIA was led by Regional Public Health in partnership with Auckland City, and involved a wide range of key stakeholders in the appraisal.

In Christchurch, an HIA has been undertaken by Community and Public Health and the City Council, involving a wide range of key stakeholders and community. HIA is a process that not only identifies potential impacts on health but is also a focus for intersectoral engagement.

Both of these HIAs have been formally evaluated.

## Collaboration issue by issue

Some DHBs are using specific issues to bring territorial local authorities (TLAs) together. In Waikato, the common concern of gambling policy for the region was the impetus to bring the 10 territorial authorities together with the DHB planners and public health staff.

## Social Environment Teams

Some Public Health Units now have “social environment” teams, providing a platform for initiating intersectoral action and participating in intersectoral initiatives at a regional level. These teams address the social determinants of health through evidence-based advice to other agencies and through active participation in interagency action, for example in the development of Regional Land Transport Strategies, Healthy Cities/Communities initiatives, and urban planning. This model should also be reflected at national level in the Ministry of Health (see previous Public Sector Leadership section).

## Māori public health leadership

There are two specific aspects of leadership for Māori public health that are vital for Māori public health action. The first is the leadership provided by Māori public health practitioners themselves, many of whom act as advisors to DHBs, PHUs, local governments etc, and others who lead public health programmes for Māori. The second type of leadership comes from kaumatua and kuia to whom many public health practitioners will refer for advice and support. Mason Durie in his Te Pae Mahutonga public health model says,

*‘While tribal and community leaders may not have technical and professional skills, they do possess an intimate knowledge of their people and have the decided advantage of being able to communicate in a vernacular that makes sense.’*

In addition, public health leadership by tribal elders has an historical basis through the well-established public health protection mechanisms that were in place long before settlement by Europeans. Many of these protections are still effective today, and are to protect the community or a resource. For example, elders can put a rahui in place to restrict access when there is a public health risk such as environmental contamination.

Māori public health leadership has also been very effective in post-colonial times<sup>37</sup> with strong recognition of the importance of the wider influences on Māori health and wellbeing, and in particular of the links between culture and health, the importance of a leadership role for Māori communities, and of Māori health workforce development.<sup>38</sup> The role of the health sector as a whole is to fully engage with Māori public health needs and to support Māori public health leadership growth and development.

<sup>37</sup> Strong leadership from Māori health professionals has characterised post colonial Māori health improvement. For example, Drs Maui Pomare and Sir Peter Buck, and more recently Dr Mason Durie.

<sup>38</sup> Ratima K, Ratima M. 2004. Māori Public Health Action: a role for all public health professionals. An opinion piece for the Public Health Advisory Committee.



## CHAPTER 6: THE WAY FORWARD

This report has emphasised that if we are to be effective at improving health and wellbeing across the New Zealand population, ensuring that no groups are left behind, investment must be made to address the social, economic, cultural and environmental contexts in which people live, work and play.

These contexts are governed by sectors other than the health services. Responses must therefore involve coordination across sectors to build healthy public policy and to enhance opportunities for people to make healthy life choices. Healthy outcomes require an intersectoral approach.

This intersectoral approach will be based on the common goals of improvements in the state of population health and wellbeing. There are clear overlaps in the health sector goals of health improvement and the goals of other sectors related to community wellbeing. By harnessing the motivation of a range of relevant sectors to work towards these goals, coordinated activity has the potential to generate better outcomes for the core goals of each sector, and thereby for the whole population.

The health sector is, but not exclusively, well-placed to take the lead in coordinating these efforts, alongside other sectors that have a requirement to address community health/wellbeing, such as local governments and transport authorities.

The way forward is complex for public health action in New Zealand but filled with opportunities for innovative solutions involving a range of key players with common goals for the improvement of health and reduction of inequalities. The PHAC is clear that the building blocks for these opportunities are all in place.

The ideal environment for effective collaborative effort to address the wider determinants of health would be based on the following:

- increased engagement of all sectors in approaches that will improve the health and wellbeing of all, ensure that no groups are left behind, and in particular, invest in actions that will improve the health of Māori and reduce inequalities of outcome
- increased investment by the health sector to address the wider determinants of health at international, national, regional and local levels, for health improvement and to reduce inequalities (investment 'upstream')
- collaborative action across sectors and at all levels (a 'whole of society' approach) to address the wider determinants of health. For this intersectoral approach to be effective, it will include:
  - effective, sustainable partnerships at all levels both within the public health sector and between sectors
  - particular emphasis on work with Māori, and by Māori, to improve the health of the Māori population
  - assessment of significant public policies for their impact on health and wellbeing (Health Impact Assessment) and a requirement that agencies outside the health sector accept responsibility for the health related outcomes of their actions
  - a funding environment that supports innovative intersectoral approaches
  - strengthened public health leadership at all levels

- public health support for agencies which do not have public health as a principal goal, but which contribute to public health outcomes
- public health capacity and capability for intersectoral public health action
- an environment of trust and collaboration.

## Recommendations:

**For a way forward to improve health and wellbeing across all population groups and to reduce health disparities between groups, the Public Health Advisory Committee recommends that the Minister of Health:**

### 1. endorse the following approaches:

- a ‘whole of government’ approach in which central and local government agencies accept responsibility for health related outcomes of their actions
- increased attention to influencing factors outside the health sector (‘the wider determinants of health’) which can improve the population’s overall health and reduce health disparities
- increased strategic capacity of public health agencies to identify new opportunities for health improvement, develop effective cross sectoral interventions and evaluate and learn from their outcomes
- increased operational capacity of public health agencies to establish and maintain collaborative ways of working across sectors and at national, regional and local levels to address the wider determinants of health
- mechanisms and support for central and local government agencies to assess the likely health impacts of their policies using techniques such as Health Impact Assessment
- improved mechanisms for information sharing across sectors and for monitoring for effectiveness of joint actions
- strong recognition of the need to involve Māori at every level of public health and to increase Māori capacity and capability to respond to Māori public health needs
- greater flexibility of funding streams to encourage innovative intersectoral public health approaches
- as a medium term goal, the implementation of the above should lead to the development of a national strategy for health and wellbeing gain agreed and owned across sectors.

### 2. request the Ministry of Health to report to you in six months with proposals and timeframes to implement approaches that would enable the Ministry to identify:

- the intersectoral collaborations with which the Ministry, District Health Boards/Public Health Units, non-government organisations and Primary Health Organisations have been or are currently involved, the difficulties and opportunities these have presented and what has been learned from them
- further intersectoral opportunities for effective collaborative action at national, regional and local levels which can improve overall health and reduce health disparities.
- the organisational capabilities required if these opportunities and emerging future ones are to be realised.

### 3. request that in preparing its report to you in six months, the Ministry of Health consider the options for action that the PHAC has identified in Chapter 6 of this report as having merit, namely:

#### Central leadership

- strategic guidance from the Ministry of Health that includes the identification of significant public health issues, effective interventions to address them, and evaluation tools to measure effectiveness
- improved capacity for technical expertise at a national level
- further development of Ministry of Health leadership in intersectoral collaboration at a central level, building on the models developed for Healthy Eating - Healthy Action and for pandemic planning
- monitoring of DHB Strategic and District Annual Plans for genuine engagement with health gain and other key public health goals

- development of mechanisms and public health support for central and local government agencies to undertake assessment of their policies for the likely impacts on health and health inequalities (Health Impact Assessment)
- ensuring public health expertise is represented in appointments to DHB Boards.

### Regional/local leadership

- provision of strategic public health direction by the core public health sector to key agencies
- ensuring public health input (including that of NGO/Māori/iwi providers) into DHB planning
- ensuring public health planning is aligned with DHB priorities along with Ministry of Health priorities
- working with DHBs to ensure public health expertise in DHB staff, (especially in Funding and Planning teams), in PHO Boards and on Community and Public Health Advisory Committees
- encouraging and assisting DHBs to invest in sustainable partnerships between local government and the health sector, and in particular with DHBs and their PHUs
- encouraging and assisting DHBs to fully engage with Māori public health needs and to support Māori public health leadership growth and development.

### Building capability

- increasing the capability of the public health workforce to lead and broker collaborative approaches to improve the health of the population
- developing a coherent overview of public health with a shared language for collaboration, and strategies for recruitment, professional development and retention
- developing clear professional pathways within occupational groups and across them
- increasing professional development opportunities that include a focus on intersectoral approaches and public health leadership skills across sectors
- increasing representation and capacity of under-represented population groups in the public health workforce, particularly of Māori
- providing opportunities for internships and secondments within the sector and across sectors.

### Funding arrangements

- developing the funding relationship between public health providers and the Ministry of Health that:
  - balances the legitimate need for accountability with the flexibility to respond to emerging issues in innovative ways
  - provides increased opportunities to address new public health challenges, particularly through intersectoral collaboration
  - reflects local priorities identified by the DHB along with national priorities.
- exploring the establishment of a funding pool, modelled on the Healthy Eating, Healthy Action Initiatives Fund, for innovative intersectoral projects that fall outside the scope of other contractual arrangements
- exploring ways to maximise the opportunities for pooled funding arrangements across government sectors that were made possible by changes to the Public Finance Act.

### Managing information

- improving mechanisms for sharing information and knowledge within the health sector and across sectors by:
  - ensuring that the implementation of the Health Information Strategy includes the development of information systems that inform public health practice and that facilitate the sharing of information across sectors.

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