

Implementing the New Zealand Health Strategy 2001

The Minister of Health's first report on progress
on the New Zealand Health Strategy

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Minister's Foreword



A year ago, I launched the New Zealand Health Strategy. Together with the New Zealand Disability Strategy, it sets the overarching guide for the development of health and disability services in New Zealand. The New Zealand Health Strategy forms a framework within which more detailed strategies are being developed and implemented in specific areas, for instance primary health care, Māori health and public health.

The release has been followed by extensive work to ensure good progress is made towards meeting the aims of the Strategy. Concurrently the new District Health Boards have been established.

The New Zealand Health Strategy sets the platform for the Government's action on health. I see it as a living Strategy. The Minister of Health will report annually on how the Strategy is being turned into reality. This process is part of the Government's accountability both to those who contributed to the development of the Strategy and to New Zealanders generally.

Implementing the New Zealand Health Strategy 2001 is the first of those reports.

Health issues impact on all New Zealanders. Given that health and disability services are potentially limitless but must operate within practical constraints, trade-offs are always involved. For this reason, the Strategy focuses on specific priority areas for improving population health and the areas where the highest benefits will come, particularly in tackling inequalities in health.

I am encouraged by the extent of progress that this first report demonstrates. The Strategy calls for a co-operative approach across the whole health sector to address common goals. I am pleased to see the emergence of such co-operation.

I congratulate all those who have helped to achieve this progress during such a busy year in the health sector, especially for the newly created District Health Boards. I am confident that the 2002 report will show that we are building well on our achievements this year, and that all New Zealanders are benefiting from our work and commitment.

A handwritten signature in blue ink that reads "Annette King".

Hon Annette King
Minister of Health

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Introduction

Under the New Zealand Public Health and Disability Act 2000, the Minister of Health is required to report annually on progress in implementing the New Zealand Health Strategy (NZHS). *Implementing the New Zealand Health Strategy 2001* is the first of these annual reports.

The New Zealand Health Strategy provides the framework within which the health sector should develop in the short to medium term. Given the importance of the Strategy to the health sector, a number of supporting strategies and action plans are being produced to ensure that its aims are achieved. Many of these strategies and plans are acknowledged within this report. A comprehensive overview of the health sector, including health sector statistics, is provided in the *Health and Independence Report* (Ministry of Health 2001a), the Director-General of Health's annual report to Parliament.

The New Zealand Health Strategy has been in place for less than a year. District Health Boards (DHBs), which will be the main agents to address the priorities of the NZHS, have been in existence for an even shorter period. For these reasons *Implementing the New Zealand Health Strategy 2001* highlights initiatives that have been taken since the launch of the NZHS, as well as those ongoing initiatives that had begun before the completion of the NZHS but which will have a significant impact on the priority population health objectives. The inclusion of initiatives that have been under way for some time will ensure that they fit in with the direction set by the NZHS.

The New Zealand Public Health and Disability Act 2000 outlines the responsibilities of DHBs and the health sector in relation to Māori. These responsibilities reflect the Crown's overall partnership with Māori under the Treaty of Waitangi. The Act has established a range of measures to further the Crown's desire for greater participation by Māori in the health and disability sector, with a view to improving Māori health outcomes and reducing health disparities between Māori and other population groups (Ministry of Health 2001b). The Ministry of Health and DHBs are expected to act in accordance with these requirements.

If you have any comments or feedback on this report, please send them to:

Sector Policy Directorate
Ministry of Health
PO Box 5013
Wellington.

Chapter 1: Background

1.1 The New Zealand Health Strategy: goals and objectives

The Minister of Health released the New Zealand Health Strategy (NZHS) in December 2000. The release followed a period of substantial consultation, involving public meetings, written submissions and reference groups.

Seven fundamental principles are identified in the NZHS, to be reflected across the health sector. These principles are:

- acknowledging of the special relationship between Māori and the Crown under the Treaty of Waitangi
- good health and wellbeing for all New Zealanders throughout their lives
- an improvement in the health status of those currently disadvantaged
- collaborative health promotion and disease and injury prevention by all sectors
- timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
- a high-performing system in which people have confidence
- active involvement of consumers and communities at all levels.

The Strategy outlines the working environment for the District Health Boards (DHBs). This environment is reflected in the funding agreements between the Boards and the Minister of Health, and in the Annual Plans of DHBs.

The Strategy contains a total of 61 population health objectives within 10 overall goals. To focus the efforts of the Ministry of Health and DHBs, 13 of the objectives have been chosen for implementation in the short to medium term. These 13 objectives are to:

- reduce smoking
- improve nutrition
- reduce obesity
- increase the level of physical activity
- reduce the rate of suicides and suicide attempts
- minimise harm caused by alcohol and illicit and other drug use to individuals and the community
- reduce the incidence and impact of cancer
- reduce the incidence and impact of cardiovascular disease
- reduce the incidence and impact of diabetes
- improve oral health
- reduce violence in interpersonal relationships, families, schools and communities

- improve the health status of people with severe mental illness
- ensure access to appropriate child health care services, including well child and family health care and immunisation.

This report highlights actions taken to implement all these objectives. Much of the responsibility for implementing the key aspects of the NZHS lies with DHBs. It is important to note that the DHBs have been in existence as separate entities only since 1 January 2001 and that the Boards were not elected until October. Therefore this first annual report does not reflect a full calendar year of activity by the DHBs.

Looking forward, the Ministry of Health is undertaking further work on how priorities can be addressed by DHBs within a framework that allows for local flexibility. For instance, Toolkits have been developed to help DHBs to address within their areas the priority health objectives identified in the NZHS. Toolkits were launched by the Minister of Health on 31 October.

1.2 The establishment of the District Health Boards and funding agreements

The major task of the DHBs in their first six months of operation has been to develop capability in their new role as funders.

The transfer of responsibilities from the Ministry of Health to the DHBs began on 1 July 2001, with the transfer of about 1,700 service agreements and other responsibilities. Further devolution took place in October, although funding for some services, such as public health, remains with the Ministry of Health for the present.

The Ministry of Health will retain responsibility as the main source of policy advice on health matters to the Government. In addition, some functions that are more cost effective to be provided nationally will remain within the Ministry. Examples are national disease surveillance tasks and collection of information relating to national health targets.

In the first half of 2001, the DHBs and the Minister of Health entered into a transitional Crown Funding Agreement. Its purpose was to enable DHBs to build planning and funding capacity through a mix of strategies involving staff retention, upskilling, recruitment and development of regional shared support agencies.

Through their annual funding agreements with the Minister of Health, the Ministry of Health and DHBs will be held accountable for implementing the NZHS. Furthermore, each DHB will be required to develop a strategic plan outlining its strategic vision for the way forward. DHB strategic plans are to be consistent with the overall direction set by the NZHS and the New Zealand Disability Strategy, and work is currently under way on these plans.

All of the DHBs have taken steps to establish formal relationships with iwi and Māori in their areas.

1.3 The development of Toolkits

To assist the health sector in implementing the NZHS, Toolkits have been developed for each of the 13 population health priority areas. These Toolkits provide the link between the strategic priority area and the work of individual DHBs. Each Toolkit has sections that:

- examine evidence and best practice in relation to initiatives that could improve health care organisations in each individual area, broken down by specific population groups (eg, age, gender, ethnicity) where appropriate
- identify areas where the health sector should interact with other agencies to undertake intersectoral action
- prioritise different interventions or programmes
- identify indicators to allow progress to be measured.

The Toolkits were developed in draft by the Ministry of Health, and have been refined with input from experts from the health sector, academic units and DHBs.

The Toolkits will be reviewed annually, reflecting the ongoing emergence of new evidence on effective programmes and treatments. Toolkits will differ in the level of information they contain, reflecting the differing amount of evidence available in each area. Some areas such as diabetes have extensive evidence and best practice to draw on; for others, such as family violence, the available evidence is more limited.

The Toolkits are a web-based application. This medium allows for easy updating, and enables users to feed back examples of good practice that others may wish to use. The Toolkits have been published on a dedicated website.¹

¹ <http://www.newhealth.govt.nz/toolkits.htm>

Chapter 2: Improving the health status of the population

This section reports on the 13 priority population health objectives in the NZHS.

2.1 Reducing smoking

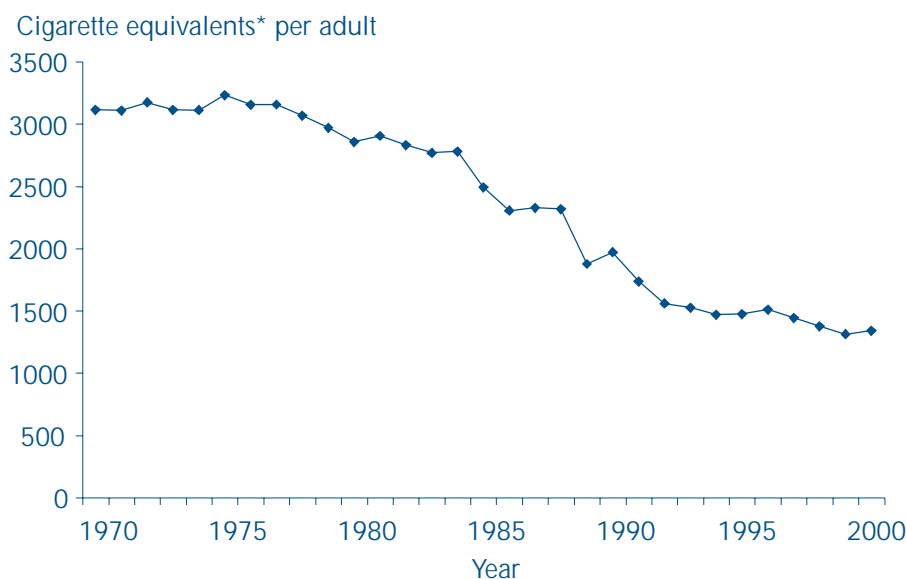
Context

Tobacco smoking kills an estimated 4,700 New Zealanders per year (Ministry of Health 2001c). Those who die early as a result of a smoking-related illness lose an average of 14 years of life compared with non-smokers (Peto et al 1994). It has been estimated that in the next 20 years 80,000 deaths in New Zealand, including 8,000 Māori, may be expected among those who are already smoking, unless they quit (Laugesen and Clements 1998). In addition, it has been estimated that approximately 388 New Zealanders will die each year from exposure to second-hand smoke (Woodward and Laugesen 2001).

A conservative estimate of the cost to society of tobacco use is approximately \$1.9 billion per annum in 1992 dollars (Public Health Commission 1994).

During the last 10 years the average number of cigarette equivalents consumed per adult decreased by more than 30 percent (Figure 2.1).

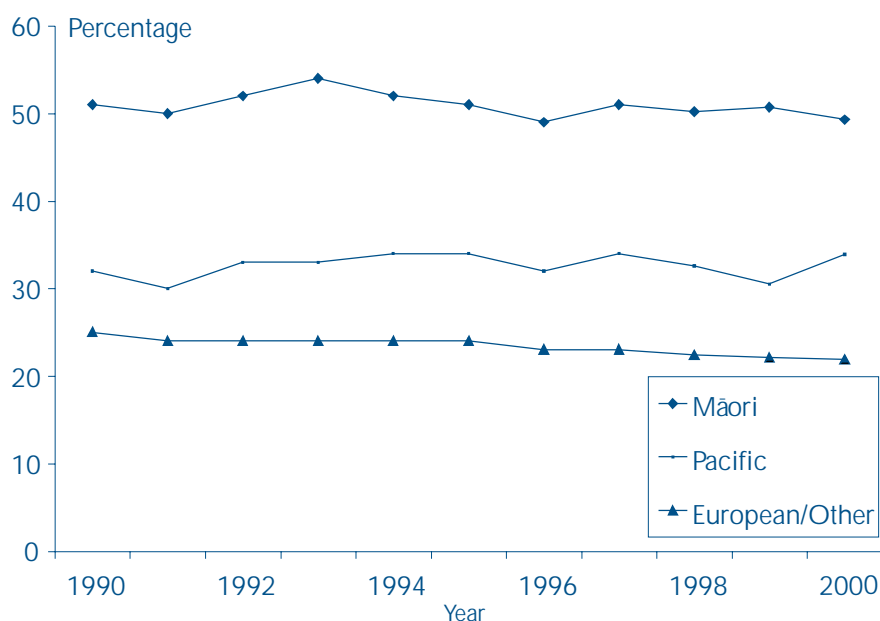
Figure 2.1: Number of cigarette equivalents* per adult aged 15 years and over, released for consumption, 1970–2000



Source: Statistics New Zealand

Note: * One cigarette equivalent equals one manufactured cigarette or one gram of loose tobacco.

Figure 2.2: Prevalence of cigarette smoking, ages 15 years and over, by ethnic group, 1990–2000



Source: ACNielsen (NZ) Ltd

As Figure 2.2 shows, the prevalence of tobacco smoking continues to be much higher among Māori and Pacific peoples than among other New Zealanders. Tobacco use has a particularly adverse impact on Māori health; some 50 percent of Māori over 15 years of age are smokers, and an estimated 31 percent of Māori deaths are attributable to tobacco use (Laugesen and Clements 1998). It is likely to be important in contributing to the higher Māori rates of lung cancer, heart disease, sudden infant death syndrome, respiratory infections, otitis media (glue ear) and the adverse outcomes of diabetes (Ministry of Health 1997a).

Youth smoking, as measured by surveys of fourth form students, increased between 1992 and 1997. Subsequent annual surveys (1998 and 1999) have found a slight decline in fourth form smoking. The 1999 survey shows a reduction notably among Māori girls and Pacific boys.

Taking the NZHS forward

- The goal of reducing tobacco smoking is being addressed through a comprehensive mix of initiatives, under the National Drug Policy in the areas of legislation and enforcement, taxation, health promotion, and smoking cessation services (Ministry of Health 1998a). Some of these initiatives are discussed in Section 2.6.
- The Toolkit *Tobacco Control* provides DHBs with information and practical advice on interventions to reduce smoking.
- A \$6.18 million programme was launched in November 2000 to assist smokers to quit by heavily subsidising nicotine replacement therapy, and ongoing funding of Quitline, which provides smoking cessation material and counselling.
- The Smoke-free Environments Act 1990 continues to be enforced, and legislation is being drafted to strengthen the Act.

- Māori have benefited from mainstream tobacco control programmes, but generally not to the same extent as non-Māori. Programmes have therefore been initiated to reduce Māori smoking rates, including:
 - the launch of a \$5 million pilot programme *Aukati Kaipapa*, to assist Māori smokers to quit by heavily subsidising nicotine replacement therapy, including a national smoking cessation programme for Māori women and their whānau. The pilot has recruited 3,000 participants who have all attempted to quit – a third are expected to quit within six months
 - the ongoing funding of *Quitline*, which has Māori as a priority group, uses Māori Quit Advisors and focuses advertising on Māori (eg, iwi radio); it received over 1,500 calls per month from Māori in March–April 2001
 - contracting for 23 new community-based cessation services
 - development of the *Noho Marae Stop Smoking Programme*
 - training 345 Māori community health workers in smoking cessation.
- Several studies have evaluated interventions specifically for Māori; responses will indicate whether programmes with a Māori focus, particularly those run by Māori for Māori, are effective.
- The Pacific Health and Disability Action Plan identifies the following actions to minimise harm to Pacific people caused by tobacco: exploring the development of Pacific Quitline and smoking cessation programmes, and encouraging smokefree Pacific environments (see Section 4.2).

2.2 Improving nutrition

Context

Nutrition plays a major role in all three leading causes of death for New Zealanders: ischaemic heart disease, cancer and stroke. Nutrition is a major determinant in the prevalence of obesity, hypertension, type 2 diabetes and dental decay. It is also a factor in determining the risk of osteoporosis and a number of gastrointestinal diseases (Ministry of Health 1998a).

Māori and Pacific peoples, and those living in deprived areas, are less likely to meet recommended intakes for vegetables and fruit consumption than other New Zealanders. While the proportion of energy intake from fat has decreased overall, mean energy intakes from fat are higher among Māori than among non-Māori. Some 55 percent of European infants are fully breastfed at three months, but only 39 percent of Māori and 44 percent of Pacific infants are fully breastfed. All groups are well below the Ministry of Health's target of 75 percent by 2000 (Ministry of Health 1999a, 2000).

There is considerable scope for reducing health inequalities by improving lifestyle choices such as diet. It is recognised, however, that policies aimed at changing habitual behaviours need to be sensitive to different sociocultural contexts and to address the underlying social inequalities themselves (Ministry of Health 1999b). A significant number of New Zealanders, especially those in Māori and Pacific households, report running out of food or being unable to eat properly because of lack of money (Ministry of Health 1999a).

Taking the NZHS forward

- The Toolkit *Improve Nutrition* provides DHBs with information, advice and evidence on key interventions to improve nutrition. It includes recommendations and approaches to target Māori and Pacific peoples.
- The Ministry of Health is developing *Healthy Food: Healthy Action*, a publication that will contain advice on nutrition, healthy weight and physical activity. The advice will guide DHBs and other service providers on programmes that contribute to improved nutrition. It will include recommendations and approaches to target Māori and Pacific peoples. This publication is expected to be completed by mid-2002.

2.3 Reducing obesity

Context

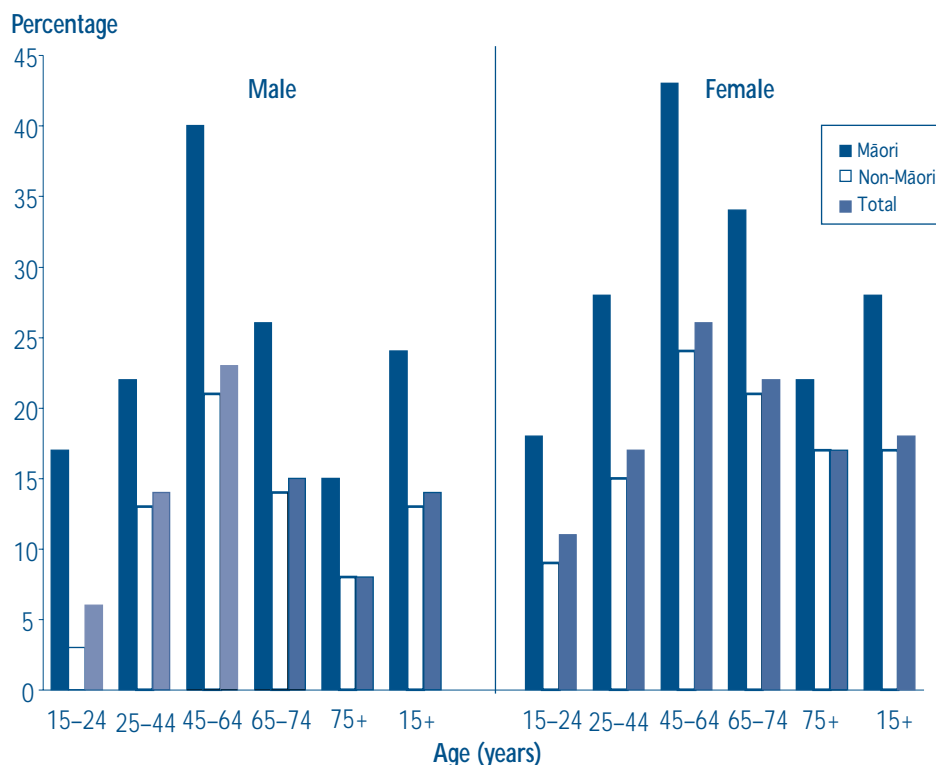
Obesity is a growing global public health problem. It is one of the most important avoidable risk factors for many serious health problems. In 1996, it was conservatively estimated that the cost of obesity to the health system in New Zealand was around \$135 million per year (Swinburn et al 1997).

There was a 55 percent increase in obesity among New Zealanders between 1989 and 1997 (Wilson et al 2001). Over half of all adult New Zealanders are now overweight or obese (Ministry of Health 1999a).

The major causes of obesity and overweight are related to nutritional factors and a lack of physical activity. Socioeconomic disadvantage increases the likelihood of poor nutrition, overweight and obesity (WHO 1998). The 1997 National Nutrition Survey showed that those living in more deprived areas, and Māori and Pacific peoples, were more likely to have poor nutrition. The diet of households of lower socioeconomic status tends to be energy dense; high fat intakes are a prominent feature while vegetables, fruit and wholegrain cereals are eaten more sparingly (WHO 1998) (see Section 2.2).

Rates of obesity among Māori exceed those of the general population: 27 percent of Māori men and 28 percent of Māori women are obese. Within Pacific populations, the prevalence of obesity is 26 percent for men and 47 percent for women. It is estimated that about 75 percent of Pacific peoples in New Zealand are overweight (Ministry of Health 1999a). Figure 2.3 provides percentages of obese New Zealanders broken down by ethnicity.

Figure 2.3: Percentage of people defined as obese by ethnic group, 1996/97



Source (base data): Ministry of Health 1999a, Bonita and Beaglehole 1998

Note: A Body Mass Index (BMI) of more than 32 is considered to represent obesity for Māori and Pacific adults. For other ethnicities the equivalent figure is a BMI of more than 30.

Overweight and obesity are important risk factors for a wide range of medical and psychosocial problems, including:

- chronic, non-communicable diseases, which lead to disability and death (eg, heart disease, type 2 diabetes, hypertension, stroke)
- debilitating conditions, which can drastically reduce quality of life and are costly in terms of absence from work and use of health resources (eg, osteo-arthritis, gallbladder disease, respiratory difficulties, infertility and skin problems)
- psychological problems (eg, low self-esteem)
- job discrimination and other forms of social stigmatisation.

Taking the NZHS forward

- The Toolkit *Obesity* provides DHBs with information and practical advice on key interventions to best reduce obesity.
- The Ministry of Health is currently developing the publication *Healthy Food: Healthy Action*, which has advice on nutrition, healthy weight and physical activity (see Section 2.2).
- The Ministry of Health has commissioned Agencies for Nutrition Action to produce a report – *Healthy Weight New Zealand 2001* – to provide an update of the current scientific understanding of weight as an index of health and health risk.
- The review *Environmental Interventions to Reduce Energy Intake or Density: A Critical Appraisal of the Literature* was published earlier this year. Undertaken by the NZ Health Technology Assessment Group, this work has fed into the development of the Toolkit for obesity and the publication *Healthy Food: Healthy Action* (see above).

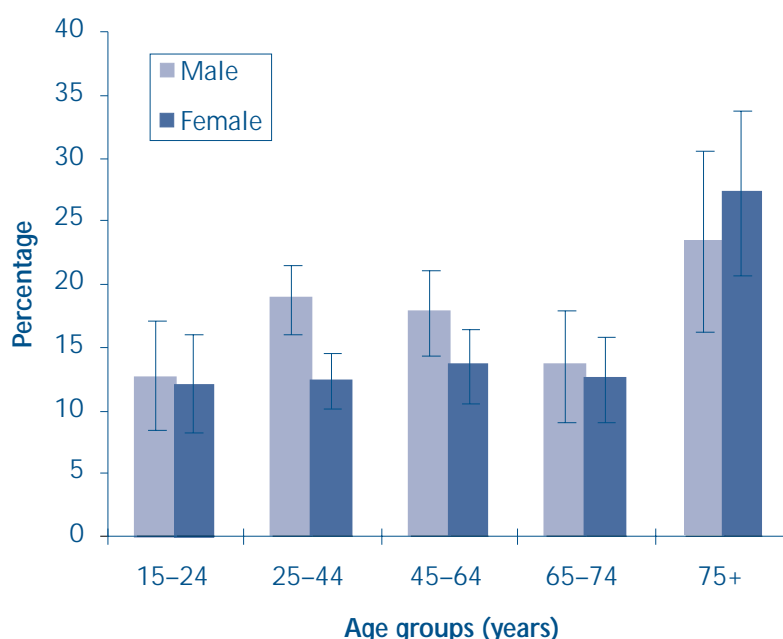
2.4 Increasing the level of physical activity

Context

One third of New Zealand adults are not physically active at levels sufficient to benefit their health. A physically active New Zealand population would benefit overall health. Physical inactivity is second to smoking as a modifiable risk factor for poor health. It is associated with 8 percent of all deaths and accounts for over 2,000 deaths per year (Ministry of Health 1999b).

Thirty minutes of physical activity of moderate intensity on most, if not all, days of the week can benefit health. Adequate levels of physical activity can reduce the risk of premature death and poor health across a number of serious diseases and conditions.

Figure 2.4: Proportion of adults who are sedentary, by age and sex



Source: Ministry of Health 1999c

Note: Error bars indicate 95 percent confidence intervals.

Levels of physical activity among Māori and non-Māori adults are similar: approximately 58 percent of Māori adults were physically active in 1997/98 (Hillary Commission 1999a). However, of those Māori who do not participate in physical activity to a sufficient level, more are likely to be sedentary (ie, participate in no activity) than the equivalent group of non-Māori (approximately 20 percent compared with 15 percent) (NHC 1998a).

In *Taking the Pulse: The 1996/97 New Zealand Health Survey* (Ministry of Health 1999c), approximately 50 percent of Pacific peoples reported that they were physically inactive, compared to 38 percent of New Zealand European and 43 percent Māori. Young Pacific people are slightly less active than Māori and New Zealand European young people (Hillary Commission 1999b).

Taking the NZHS forward

- The Ministry of Health has developed the Toolkit *Physical Activity* for DHBs. This Toolkit includes a specific focus on increasing physical activity among Māori and Pacific peoples.
- The Hillary Commission currently leads the promotion of physical activity. It runs a number of programmes that aim to encourage inactive people to become more active, such as *Push Play*, *Green Prescription Scheme* (see below), *Movement = Health* and *He Oranga Poutama*.
- A Recreation and Sports Agency is planned to bring together the Hillary Commission, the Sports Foundation, and the sport and recreation functions of the Office of Tourism and Sport. It is intended that key programmes that have previously been delivered by the Hillary Commission such as *Push Play* and *Green Prescription Scheme* will continue to be provided at a national level and through regional sports trusts.
- The Ministry of Health, Pharmac and contracted providers have continued to support the *Green Prescription Scheme*, which was implemented nationally in 1999 after randomised controlled trials demonstrated its effectiveness. A Green Prescription is a general practitioner's written advice to a patient to be physically active as part of the patient's health management. The programme assists a number of priority groups identified in the *Physical Activity* Toolkit.
 - As at May 2001, half of general practitioners and all independent practitioner associations were issuing green prescriptions.
 - Green Prescriptions are prescribed mainly to women (77 percent), and mainly to lose weight (49 percent), with walking as the activity prescribed in 84 percent of those cases.
 - The majority of patients receive prescriptions to address weight issues for 49 percent (versus 25 percent in 2000), high blood pressure/stroke for 29 percent (versus 16 percent), diabetes for 23 percent (versus 7 percent), high cholesterol for 23 percent (versus 6 percent) and stress/anxiety for 17 percent (versus 5 percent).
 - Six months after it was prescribed, 54 percent were still enjoying the activity (Hillary Commission 2001).
- Contracted providers of public health services continue to support the Hillary Commission's *Push Play* programme. *Push Play* promotes the importance of all New Zealanders doing 30 minutes of moderate intensity physical activity on most, if not all, days of the week (Hillary Commission 1999a).
- The Ministry of Health is developing the publication *Healthy Food: Healthy Action*, that provides advice on nutrition, healthy weight and physical activity (see Section 2.2).
- The Ministry of Health is working with the Hillary Commission and Statistics New Zealand to develop physical activity monitoring systems and processes, including an improved survey (due December 2001).

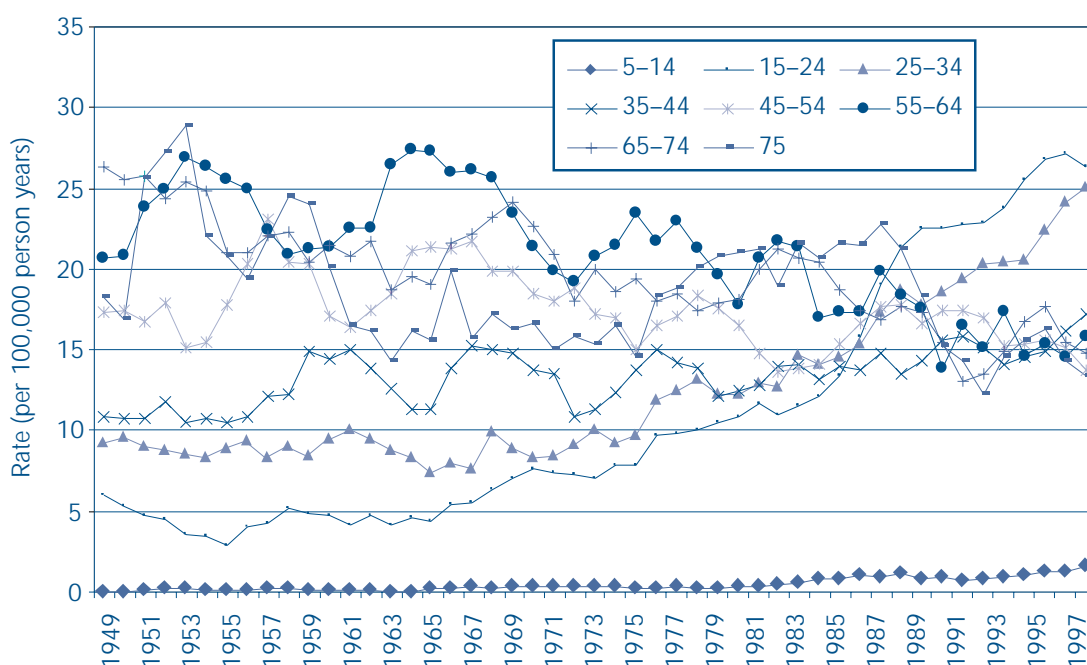
2.5 Reducing the rate of suicide and suicide attempts

Context

Suicide and suicide attempts are a significant public health issue, and a major source of morbidity, mortality, social and health costs. In 1997 in a comparison with selected OECD countries,² New Zealand had the highest rate of youth³ suicide. Across all ages it was amongst the highest for total suicide rates. In terms of potential years of life lost (PYLL),⁴ suicide ranks third for both males and females⁵. (NZHIS 2001)

Young people account for about a quarter of all suicides. Indications are that youth suicide is declining. However, rates for the total population have not yet shown a tendency to decline or stabilise.

Figure 2.5: New Zealand age specific suicide rates (three-year moving average) 1949–1997



Source: NZHIS

² The selected OECD countries include New Zealand, Finland, Australia, Norway, Japan, Sweden, Canada, the Netherlands, France, the United States, Germany and the United Kingdom.

³ 'Youth' is defined as people aged 15–24 years.

⁴ PYLL is a method of measuring premature mortality. An arbitrary age (70 years in this case) is assigned as an age at which any deaths would not be considered premature. Suicide ranks high in $PYLL_{70}$ because of the high number of suicide deaths at a younger age compared with deaths from cancer or ischaemic heart disease.

⁵ While suicide accounted for approximately 2 percent of all deaths in 1997, in terms of potential years of life lost ($PYLL_{70}$) from leading causes of death, suicide ranks third for males after cancer and ischaemic heart disease and third for females after cancer and motor vehicle crashes.

There are multiple risk factors for suicide, many of which are generic to a range of poor health outcomes. Most suicidal behaviour occurs in the context of mental illness (principally depression) and/or substance abuse (Beautrais, Joyce, and Mulder, 1997; Fergusson and Lynskey 1995). The best opportunities for suicide prevention lie with developing more effective approaches for promoting mental health, preventing mental illnesses and providing early treatment and support for those with mental illnesses.

Social and educational disadvantage is one of the risk factors for suicidal behaviour (Beautrais, Joyce, and Mulder 1998). Many preventive interventions therefore need to target Māori and disadvantaged population groups.

Suicide prevention requires comprehensive action across a range of government and community sectors. The health sector plays a pivotal role; it needs a well-integrated programme of activities across public, primary, personal and tertiary health services. The complexity of suicidal behaviour and the nature of cumulative risk mean that intersectoral approaches are required and that it is unrealistic to expect significant reductions in the short term.

Taking the NZHS forward

- The *New Zealand Youth Suicide Prevention Strategy* provides a framework of initiatives to be taken across government agencies and communities (Ministry of Youth Affairs, Ministry of Health and Te Puni Kōkiri 1998). The strategy has two components: *In Our Hands* aims to reduce suicide for all youth; *Kia Piki Te Ora o Te Taitamariki* is targeted specifically at Māori youths. While this strategy is targeted at reducing suicidal behaviour among 15 – 24-year-olds, many initiatives have relevance across the whole life span.
- The *Toolkit Suicide Prevention* provides DHBs with information and practical guidance on key interventions to reduce the rate of suicide and suicide attempts.
- Guidelines and best practice resources on identifying and managing people at risk of suicide have been developed for primary healthcare professionals and are being developed for personnel in mental health services and emergency departments.
- Several major research projects into suicide (including Māori and Pacific suicide) have been and continue to be funded.
- Regional mental health promotion initiatives have been undertaken, such as regional suicide prevention co-ordinators in some areas, school based youth mental health projects, and rangatahi Māori health and wellbeing projects.
- Expansion of child and youth mental health services, including workforce development.
- An intensive community development initiative that aims to reduce suicidal behaviour by strengthening Māori communities to be more responsive to the needs of young Māori has been established in six sites.
- A national training and skills development programme for Māori on youth suicide prevention is in development.
- It is intended that in their first year (2001/2002) DHBs will be responsible for promoting and encouraging the use of the following guidelines through their contracted primary care providers:
 - *Guidelines for Primary Care Providers: Detection and Management of Young People at Risk of Suicide* (Ministry of Youth Affairs 1999)

- *Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals* (NHC 1996)
- *Guidelines for Assessing and Treating Anxiety Disorders* (NHC 1998b)
- *Guidelines for Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care* (NHC 1999).

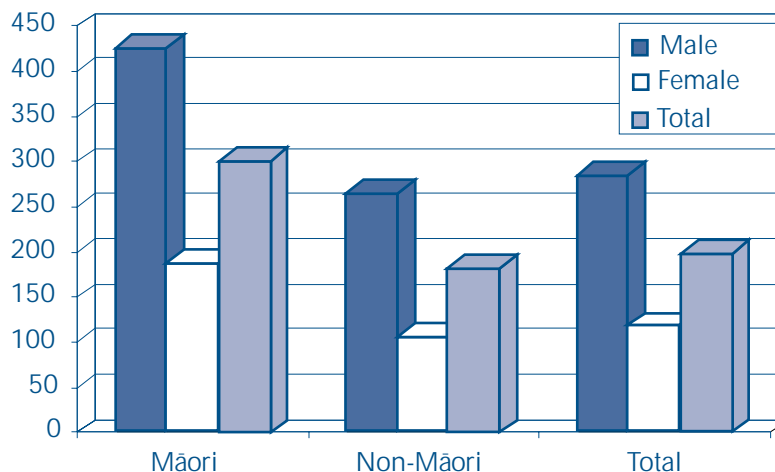
2.6 Minimising harm caused by alcohol and illicit and other drug use to individuals and the community

Context

Substance abuse causes significant harm to the health and social wellbeing of New Zealanders. The annual social cost of alcohol misuse has been estimated at between \$1.5 billion and \$2.4 billion (Devlin, Scuffham and Bunt 1996). Among those aged 21 years, 9 percent can be expected to be dependent on cannabis (Fergusson and Horwood 2000). About 45 percent of all identified injecting drug users are infected with hepatitis C (Kemp and MacDonald 1999).

Evidence indicates that Māori suffer disproportionate harm from alcohol and cannabis misuse compared with the rest of the population. Pacific peoples who consume alcohol are also more likely to exhibit hazardous drinking patterns than the general population.

Figure 2.6: Māori and non-Māori rates* of hospitalisation+ for alcohol-related conditions,# 1998



Source: New Zealand Health Information Service

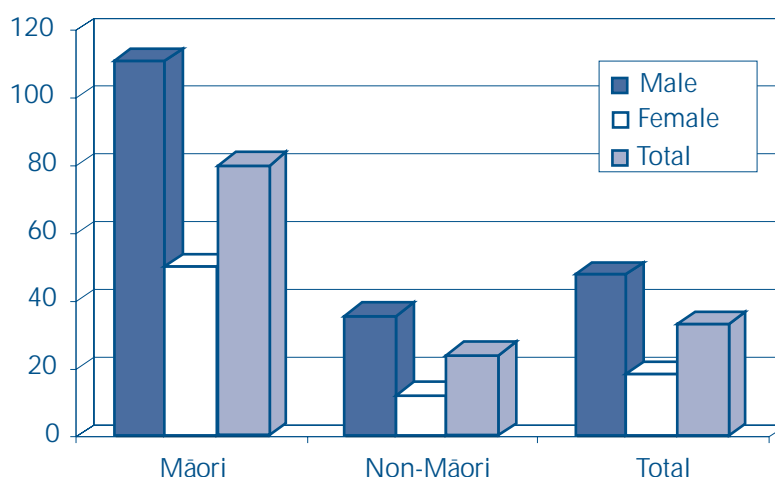
Notes:

* Rates per 100,000 population, age-standardised to Segi's world population.

+ Publicly funded hospitalisation for inpatients and day patients only.

Alcohol-related conditions include psychoses, dependence syndrome, nondependent use disorder, gastritis, liver disease, pancreatitis and poisoning.

Figure 2.7: Māori and non-Māori rates* of hospitalisation+ for cannabis-related conditions,# 1998



Source: New Zealand Health Information Service

Notes:

* Rates per 100,000 population, age-standardised to Segi's world population.

+ Publicly funded hospitalisation for inpatients and day patients only.

Cannabis-related conditions include psychoses, dependence, nondependent abuse and poisoning.

Two initiatives that predate the New Zealand Health Strategy and form part of the policy framework to minimise alcohol and drug related harm are the National Drug Policy (Ministry of Health 1998a) and the National Mental Health Strategy (Ministry of Health 1994, 1997b).

The National Drug Policy forms a comprehensive, intersectoral strategy to reduce all legal and illegal drug-related harm. Taking a three-pronged approach, it focuses on:

- supply control – limiting the availability of drugs, eg, through law enforcement
- demand reduction – reducing the desire to use drugs, eg, through education programmes
- problem limitation – mitigating the harm already caused by drugs, eg, through treatment services.

Taking the NZHS forward

- The Ministry of Health has developed the Toolkit *Minimising Alcohol and Other Drug Related Harm*. It provides DHBs with practical advice on key interventions to minimise harm from alcohol and other drugs to both individuals and the community, including recommended interventions targeted at important population groups.
- The *National Alcohol Strategy* (ALAC and Ministry of Health 2001) forms an important subsection of the National Drug Policy. It incorporates a range of strategies designed to minimise alcohol-related harm. It identifies Māori and Pacific peoples as at high risk and details harm-reduction strategies specific to these groups.
- The *National Strategic Framework for Alcohol and Drug Services* has recently been developed (Ministry of Health 2001d). It provides guidelines for DHBs in relation to providing services for people with severe substance abuse problems, including Māori and Pacific peoples.

The Misuse of Drugs Act 1975 has been amended to provide a more rapid means to classify and therefore regulate newly emerging and existing drugs, on the basis of their potential harm. As part of this process the Expert Advisory Committee on Drugs (EACD) has been established, which assesses drugs and makes classification recommendations to the Minister of Health.

- A review of the protocol for methadone maintenance treatment is under way.
- Professional development programmes have been developed for schools to assist teachers in delivering drug education. This initiative has been led by the Ministry of Education.
- The Alcohol Advisory Council (ALAC) is leading three Northland pilot projects to develop, implement and evaluate strategies to reduce alcohol-related harm in Māori communities. ALAC is also running several projects aimed at Pacific peoples.
- Tahua Kaihoatu is an existing fund, administered by Te Puni Kōkiri, for the development of Māori providers. It delivers social services that contribute to whānau and community development.

Limited information is available on successful interventions for Pacific peoples. Further research is necessary to establish data as a foundation for developing effective treatment and prevention of alcohol-related harm among Pacific peoples. Such research will be carried forward in work arising from the Pacific Health and Disability Action Plan (see Section 4.2).

2.7 Reducing the incidence and impact of cancer

Context

Cancer is the second leading cause of death (27 percent) and a major cause of hospitalisation (7 percent) in New Zealand (Ministry of Health and NZHIS 2001; Ministry of Health 1999b). There are over 16,000 new cancer registrations each year; the highest rates are in the middle and older age groups. In 1997 New Zealand's mortality rate for cancer was the sixth highest among a selection of OECD countries (Ministry of Health and NZHIS 2001).

Of cancer registrations, the most common sites for males are the prostate, large bowel and lung; for females they are the breast, large bowel and melanoma of the skin. Common causes of cancer deaths for males are cancer of the lung, large bowel and prostate; for females they are cancer of the breast, lung and large bowel (Ministry of Health and NZHIS 2001).

Evidence indicates that some cancers, particularly smoking-related, liver and cervical cancers, affect Māori and Pacific peoples more than the rest of the population. Māori are therefore a target group for policies to reduce smoking, for hepatitis B vaccination and screening, and for regular cervical screening.

Māori have considerably higher registration rates than non-Māori for cancer of the liver, stomach, lung and cervix. Māori registration rates for female breast cancer are also slightly higher. On the other hand, Māori registration rates for cancer of the prostate and colon are considerably lower than for non-Māori (Ministry of Health and NZHIS 2001).

A co-ordinated approach is being developed across health promotion and prevention activities, early detection (particularly screening), treatment, rehabilitation and palliative care.

Taking the NZHS forward

- The Ministry of Health has developed the Toolkit *Cancer Control*. It provides DHBs with information, advice and evidence on key interventions to reduce the incidence and impact of cancer. It makes recommendations specifically targeted at interventions for Māori and Pacific peoples. It also has strong links with other Toolkits dealing with population health issues that influence cancer, such as *Tobacco Control*, *Improve Nutrition*, *Physical Activity* and *Obesity*.
- A national cancer control strategy is being jointly developed by the Ministry of Health and the New Zealand Cancer Control Trust. A background paper and scoping plan for the strategy have been completed this year. The next stage is to develop the strategy itself, which will cover the range of services from health promotion, prevention, detection, treatment and rehabilitation to palliative care. It is expected to be finalised by December 2002.
- The Cancer Treatment Working Party has released its report *Improving Non-surgical Cancer Treatment Services in New Zealand*. The report draws on an intensive review of cancer services undertaken by three specialist working parties: Radiation Oncology, Medical Oncology and Haematology. They identified the key issues related to service delivery that need to be considered to improve equity of access for New Zealanders who require cancer treatment. The report also outlines the Ministry of Health's response.
- Work is in progress to implement the recommendations of the Gisborne Cervical Cancer Inquiry to improve the National Cervical Screening Programme, whose long-term aim is to reduce rates of invasive cancer.
- Hepatitis B vaccination and screening programmes have Māori as a priority target group. A priority for the *National Cervical Screening Programme* is to increase participation by older Māori women in the programme.
- Other priorities in the NZHS will help to reduce the incidence and impact of cancer, including *Reducing Smoking*, *Improving Nutrition* and *Improving Physical Activity*.
- The *Palliative Care Strategy*, released in February 2001, establishes a systematic and informed approach to the provision and funding of palliative services.

2.8 Reducing the incidence and impact of cardiovascular disease

Context

Cardiovascular disease is the leading cause of death in New Zealand, accounting for 41 percent of all deaths in 1997. This category incorporates a number of heart- and vascular-related diseases such as coronary artery disease, rheumatic heart disease and cerebrovascular disease. Although declining in New Zealand, coronary artery disease results in the most deaths of any cardiovascular disease. Stroke is responsible for the second highest number of deaths among cardiovascular diseases and is the most common single cause of severe disability in older people (Ministry of Health 1998b).

Mortality from all cardiovascular diseases is higher among Māori than among the general population. However, mortality rates for cerebrovascular disease are higher among Pacific peoples than among Māori and other New Zealanders.

The financial cost of cardiovascular disease in New Zealand is considerable. In the early 1990s the annual cost of coronary artery disease alone was estimated at between \$306 million and \$467 million (\$179 million in direct costs). Cardiovascular drugs cost in excess of \$100 million a year and contribute to over 20 percent of Pharmac expenditure (Pharmac 2001).

Taking the NZHS forward

- The Toolkit *Cardiovascular Disease* provides practical advice on interventions to reduce the incidence and impact of cardiovascular disease.
- A Cardiovascular Action Plan has been developed as a result of the work of the expert advisory group (discussed below). It forms the basis for the Toolkit *Cardiovascular Disease* and sets the direction for future cardiovascular development. The Cardiovascular Action Plan identifies as priorities: risk assessment and primary prevention; acute coronary syndromes; secondary prevention; cardiac rehabilitation; development of organised stroke services; cardiovascular disease and Māori; cardiovascular disease and Pacific peoples.
- An expert advisory group has been established to work with the Ministry of Health in providing strategic direction for work underway in the cardiovascular area.
- Comprehensive guidelines are to be developed to address both the primary and secondary prevention of cardiovascular disease. The feasibility of introducing a cardiovascular risk screening programme based in the primary care setting will also be determined.
- In regard to acute coronary syndromes, the Ministry of Health has established a working party to determine how access to thrombolysis can be increased for rural people who have had a myocardial infarction, based on guidelines currently being completed by the Cardiac Society. Research has shown that when general practitioners provide community thrombolysis (in conjunction with cardiologists) for patients who have had an acute myocardial infarction, the extent of cardiac damage can be reduced.
- In addition, the Cardiac Society is developing guidelines on acute coronary syndromes. After their completion, which is expected to be by early 2002, and once they are approved by the Ministry of Health and the New Zealand Guidelines Group, the Ministry hopes to undertake joint work with DHBs to determine the extent to which standardised acute pre-hospital and hospital care for people with acute coronary syndrome can be implemented.
- The Heart Foundation has been compiling guidelines for cardiac rehabilitation in conjunction with the New Zealand Guidelines Group. Once these guidelines have been completed, the Ministry of Health will set up a working group with DHBs to review cardiac rehabilitation services, as these currently vary in access, provision and quality throughout New Zealand.
- The Ministry of Health has a contract with the Stroke Foundation to update its stroke guidelines for providers. The Ministry is also in the process of establishing a working group with DHBs to determine the feasibility of developing organised stroke services throughout New Zealand.
- A Māori working group is being established to develop an action plan aimed at reducing or eliminating cardiovascular disparities between Māori and non-Māori. This working group will operate under the principles of the Treaty of Waitangi, and the themes of partnership, participation and protection. It will also link with and provide input to the work in each of the other cardiovascular priority areas.

- A working group of Pacific peoples is to be set up to produce an action plan aimed at improving cardiovascular outcomes for Pacific peoples. It will also link with the work in each of the other cardiovascular priority areas.
- A number of integrated care projects are under way in New Zealand for people with heart failure.
- The Rheumatic Fever Trust is investigating selected schools in South Auckland to determine whether early diagnosis and treatment of streptococcal pharyngitis will decrease the incidence of rheumatic fever.

2.9 Reducing the incidence and impact of diabetes

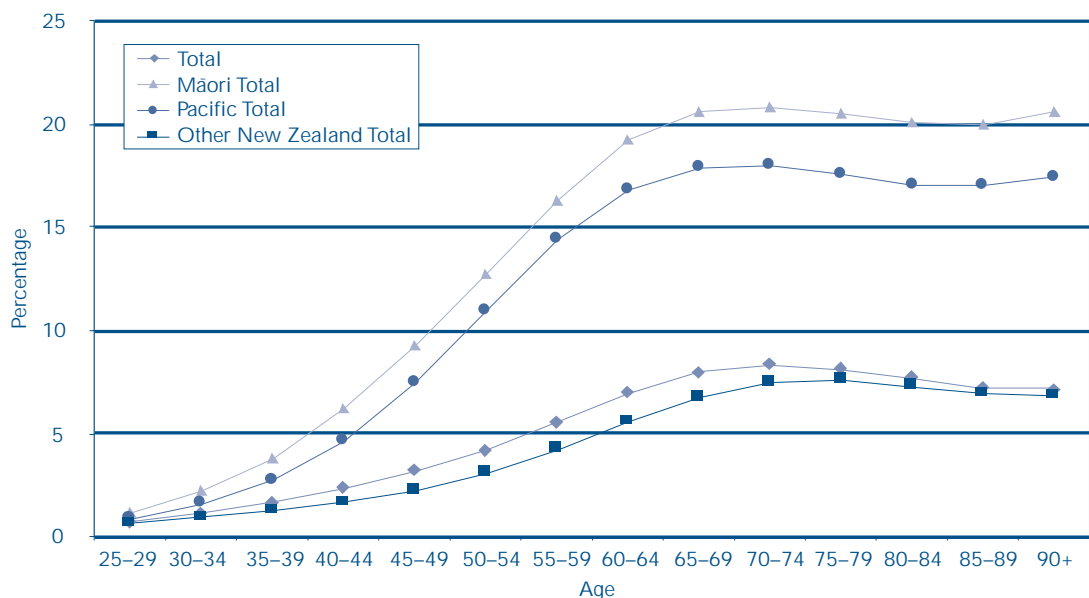
Context

While diabetes takes a number of forms, types 1 and 2 diabetes predominate. Type 1 diabetes is an autoimmune condition of unknown cause, and is not currently preventable. It requires lifelong administration of insulin to regulate blood glucose. Type 2 diabetes results from reduced insulin production or effectiveness. Typically it has been older people who develop type 2 diabetes but it is increasingly being diagnosed in younger people. The main factors contributing to these trends in type 2 diabetes are increasing levels of obesity and physical inactivity in the New Zealand population.

The impact of diabetes in terms of illness and mortality is significant and will become more so as the prevalence of type 2 diabetes increases along with levels of obesity and physical inactivity in the community. The prevalence of diagnosed diabetes across the population of New Zealand is estimated at around 4 percent. Type 2 diabetes represents about 95 percent of known diabetes in Māori and Pacific peoples, and about 89 percent in New Zealand Europeans. The prevalence of diabetes in Māori and Pacific populations is around three times higher than among other New Zealanders. Type 2 diabetes in particular is a major and increasing problem in Māori and Pacific populations and lower socioeconomic groups.

Estimates of the prevalence of known diabetes in New Zealand (from modelling undertaken by the Ministry of Health) are summarised in Figure 2.8.

Figure 2.8: Type 2 diabetes prevalence rate by ethnicity



Extrapolating from recently published Australian findings, it is estimated that as many New Zealanders may be living with undiagnosed (and therefore untreated) type 2 diabetes as the number who are known to have diabetes (International Diabetes Institute 2001).

Taking the NZHS forward

- The Ministry of Health has developed the Toolkit *Diabetes* for DHBs, which identifies specific interventions to reduce the incidence and impact of diabetes.
- The *Diabetes 2000* implementation plan is being rolled out, with particular emphasis on the high-risk populations of Māori and Pacific peoples. Actions taken include the following:
 - Local Diabetes Teams are functioning across the country. They provide advice and identify areas of need to DHBs. They are required to have Māori and Pacific representation.
 - An extra \$1.5 million per annum has been committed to diabetes services to address variability in the availability of high quality diabetes services, particularly for the groups at highest risk.
 - Free annual checks for all people with diabetes are now available across the country at primary care level. Data from these checks are creating an invaluable resource for data analysis and future needs assessment. Māori providers, Pacific providers, and iwi have been contracted to provide checks in a culturally appropriate manner.
 - Eye screening volumes were adjusted to improve access to retinopathy screening for people with diabetes. Māori have higher rates of diabetic retinopathy than the general population and will benefit from increased screening volumes and from DHB initiatives, such as mobile screening services.
 - A national quality assurance programme for retinopathy screening is to be developed, with a contract to be let in 2001/02.
 - The Ministry of Health and the Health Research Council of New Zealand are jointly funding community-based research into the primary prevention, screening and treatment of diabetes, with a particular focus on Māori and Pacific populations. The three-year \$1.5 million project is designed to provide evidence for primary prevention, screening and treatment.
 - The Ministry of Health is developing an evaluation tool, which will be used to assess the performance and quality improvement of diabetes services. A draft tool has been piloted in one DHB area; it specifically focuses on ensuring that diabetes services meet the needs of Māori and Pacific peoples.
 - During 2000/01 six original waiata were recorded on CD in te reo Māori for distribution to iwi radio stations, to raise awareness of diabetes among Māori.

2.10 Improving oral health

Context

Diseases of the teeth and gums are among the most common health problems and are experienced by all New Zealanders at some stage of their life. Dental problems cause much pain and discomfort and often contribute to a loss of self-esteem. Māori and Pacific children and adolescents have worse oral health than other New Zealand children. While the long-term trend has been towards better dental health in New Zealand children, progress was slower in the 1990s.

Taking the NZHS forward

- The Ministry of Health has progressed the New Zealand Health Strategy objectives for oral health in three main areas – school dental service, adolescent oral health, and fluoridation.
- The Ministry of Health has developed the Toolkit *Improve Oral Health* for DHBs.
- The Standards Technical Advisory Group (Standards TAG) has developed 12 guidelines for the school dental service, which form part of the Toolkit for oral health.
- Regarding adolescent oral health, the Ministry of Health:
 - has commissioned a review of publicly funded oral health services for adolescents and payment arrangements related to the delivery of the services. Public feedback on these recommendations has been sought
 - has extended eligibility for funded oral health care to include all adolescents up to the age of 18. Previous eligibility for this free service applied only to those who were in full-time education approved by the New Zealand Qualifications Authority, or on certain Department of Work and Income benefits
 - is introducing a new contract for teenage dental care (Oral Health Agreement), aimed at improving teenagers' uptake of dental care and increasing preventive dental care. Over the next five years the aim is to increase use of the service from 63 percent to 85 percent of under 18-year-olds. The Oral Health Agreement is predicated on targeting at-risk populations and increasing population coverage, and introduces new quality requirements
 - has convened a reference group to adapt the existing clinical guidelines for the school dental service to the adolescent population.
- The Ministry of Health hosted a forum in June 2001 in recognition of the significance of water fluoridation as a highly effective public health measure for oral health, particularly for children, Māori and disadvantaged people. The purpose of the forum was to develop recommendations for strategies to: protect those areas that have water fluoridation; promote water fluoridation in those areas that need it; and identify national health education resources.
- An Oral Health Advisory Group (OHAG) has been established to facilitate sector leadership in dental and oral health. This will contribute to the development and adoption of new and innovative systems in the delivery of dental and oral health care.

2.11 Reducing violence in interpersonal relationships, families, schools and communities

Context

It is important for the health and disability sector to address interpersonal violence because it is common, associated with a significant burden of disease both in the short and long term, and costly to individuals and to society.

In New Zealand there is a significant level of violence in interpersonal relationships, families, schools and communities. In the year to June 2000, records show 6,833 children were abused or neglected (Ministry of Social Policy 2001). It is estimated that one in seven families experience violence (Snively 1994). It is also estimated that 3 percent to 5 percent of older people are victims of elder abuse (Age Concern New Zealand 1999, Williams, Neale and Preston 1998). Fifty percent of New Zealand school children find bullying a problem and around 8 percent experience persistent, very serious harassment (Smith and Sharp 1994). Violence in Māori whānau is higher than in non-Māori families (Young et al 1997).

Violence impacts on the health and disability sector both directly and indirectly. Victims of abuse seek care from health care providers at far greater rates than those who have not experienced abuse. They seek such care not only for assault-related injuries, but also for a range of other health effects.

On average, nine children aged 0–14 years died each year from assault between 1993 and 1997 (Ministry of Health 2000). Hospitalisation data on assault of children significantly under-represent the total because many child injuries are not treated, and injury is often internal and not visible. Each year about 400 women are hospitalised and 11 die as a result of assault (NZHIS 1999).

Taking the NZHS forward

- The Ministry of Health has developed the Toolkit *Reduce Interpersonal Violence* for DHBs. It recommends population-based strategies to reduce violence in interpersonal relationships, families, schools and communities, and health sector protocols to identify and respond to violence.
- The new *Family Violence Intervention Project* will be the focus of the health sector response to interpersonal violence in 2001–2004. This project will assist providers in developing appropriate protocols to identify family violence and refer appropriately, in establishing effective training programmes for providers, and in initiating public education campaigns. It is intended that the project will set up sites of good practice in a small number of Māori and Pacific providers. The Ministry of Health has consulted on a draft model protocol with nursing, medical and allied health professional groups (Ministry of Health 2001e). Strong support for the project has been indicated.
- Reducing violence is a new priority for public health. Public health funding for initiatives to reduce violence is used primarily to support projects that develop personal skills in school students and parents and build supportive social networks, raise public awareness and build community capacity to address violence issues.

- The Ministry of Health provides some funding for public health programmes delivered in family/whānau, school and other community settings. Examples are *The Eliminating Violence Programme*, *He Whānau Piripono He Iwi Pakari*, building blocks to peaceful communities (delivered by the Special Education Service), a programme that involves family/whānau through kōhanga reo, *Peaceful Waves/Matangi Malie* delivered through Samoan and Tongan churches (Special Education Service) and *Cool Schools* (New Zealand Peace Foundation).
- DHB Public Health Units and a range of iwi providers are also involved in health promotion to counter child abuse and domestic abuse.
- *Recommended Referral Process for GPs: Suspected child abuse and neglect* and a training package have been distributed to all general practitioners. The material gives clear guidelines on managing and referring suspected cases of child abuse.

2.12 Improving the health status of people with severe mental illness

Context

The National Mental Health Strategy, *Looking Forward: Strategic directions for the mental health services* (Ministry of Health 1994), is directed towards more and better services for the 3 percent of adults and 5 percent of children and young people who suffer from the most severe mental disorders.

The strategic framework for specialist services for children and young people, *New Futures*, sets benchmarks for access to services at about 3 percent (Ministry of Health 1998c). Funding has been targeted at 3 percent of the total population. Beyond the provision of treatment services in secondary and primary settings, it is intended that, through greater intersectoral action, issues of education, housing, stigma and discrimination will be addressed to help meet people's full range of needs.

The *Blueprint for Mental Health Services* developed by the Mental Health Commission continues to be implemented (Mental Health Commission 1998). The *Blueprint* draws on *Looking Forward*, and also *Moving Forward* (Ministry of Health 1997b).

Taking the NZHS forward

- The Ministry of Health has developed the Toolkit *Mental Health* for DHBs. This Toolkit identifies key interventions to improve the mental health status of people with severe mental illness.
- The Ministry of Health has developed *Building on Strengths: A new approach to promoting mental health in New Zealand/Aotearoa*, which will be available for implementation by the end of the year.
- New Zealand Standards (2001) has developed *The National Mental Health Sector Standard: He Whāriki Oranga Hinengaro*.

- The Mental Health Commission (2001) has released its *Report on Progress 1998–2000: Towards implementing the blueprint for mental health services in New Zealand*. It showed that progress has been good. Services have increased in almost all areas and important quality initiatives have been established.
- The Ministry of Health (Ministry of Health 2001f) has developed *Te Puawaitanga: Māori Mental Health National Strategic Framework*.
- The Ministry of Health (Ministry of Health 2001g) has developed *National Plan 2001–2003: Project to counter stigma and discrimination associated with mental illness*.
- *Tuutahitia Te Wero, Meeting the Challenges: Mental health workforce development plan 2000–2005* continues to be implemented (HFA 2000).
- Early results on the Project to Counter Stigma and Discrimination associated with Mental Illness, *Like Minds, Like Mine*, are promising. It has been found that 58 percent of the public are aware of the television advertising messages. Supporting the campaign are local activities that bring people with experience of mental illness into contact with influential individuals and groups.

Actions to improve the health status of people with severe mental illness are discussed in further detail in Section 3.4.

2.13 Ensuring access to appropriate child health care services including well child and family health care and immunisation

Context

Achieving good child health is a worthwhile objective in its own right. Moreover, its achievement is vital for adult health, as the risk factors for many adult diseases and the opportunities to prevent these diseases arise in childhood. Poor child health and development can have an adverse and long-term impact on broader social outcomes, including sexual and reproductive health, mental health, violence, crime and unemployment.

Large disparities in health status exist among population groups. Tamariki Māori, Pacific children and children from low-income families experience comparatively poorer health outcomes than the overall child population.

Breastfeeding rates provide one key indicator for child health (Table 2.1). In New Zealand rates of breastfeeding initiation are high but decrease significantly over the first three months after birth. Māori mothers and babies show the largest decrease.

A second key indicator is hearing screening tests at school entry (Table 2.2). School-entry screening for hearing loss should have 100 percent coverage and a 95 percent pass rate. The total population is approximately 7 percent below the target pass rate, and Māori and Pacific children are almost 15 percent below the target pass rate.

Table 2.1: Full breastfeeding rates at six weeks and three months after birth

	Total	Māori	Pacific peoples	Other
Six weeks	65.1	59.0	60.1	67.5
Three months	50.7	39.6	44.6	54.4

Source: Ministry of Health 2001h

Note: Data are for the 1999/2000 financial year.

Table 2.2: Percentage passing school entry hearing screening test

	Total	Māori	Pacific peoples	Other
New Zealand	92.3	86.2	86.1	94.7

Source: National Audiology Centre 2000

Note: Data are for the 1998/99 financial year.

Taking the NZHS forward

- The Ministry of Health has developed the Toolkit *Immunisation* for DHBs, which includes interventions that will contribute to the priority objective of appropriate access to child health services including immunisation.
- The Ministry of Health is establishing the Child and Youth Mortality Review Committee. It is intended that this Committee will help to reduce preventable deaths by identifying contributory factors and making recommendations that inform policy and service development, improve professional practice, inform education and contribute to research.
- The *Baby Friendly Hospital Initiative* (BFHI) is being implemented. The World Health Organization and UNICEF developed the BFHI in 1989 to improve breastfeeding in hospitals and maternity facilities. Following the baseline pre-assessment for the BFHI conducted this year, a national benchmarking report is being finalised. It is intended that DHBs will use the benchmarking report to move maternity facilities toward BFHI certification.
- *Outreach Services* for childhood immunisation, which are effective in improving immunisation uptake for children whose parents have not accessed immunisation services through primary care, are being developed. Service specifications, priority frameworks and prioritised areas for targeting *Outreach Services* have been established. Contracting of providers to deliver *Outreach Services* will begin shortly.
- A new *Well Child Framework* has been developed to ensure that all children receive their entitlement for well child services between birth and five years of age. The framework allows additional support for families with higher needs and for first-time parents. The Ministry of Health will be working with DHBs until the end of 2001 with the goal of implementing the framework for all well child providers over the next two to three years.

Chapter 3: Improving health services

The NZHS identifies service priority areas that will be particularly important in taking forward its aims. These priority areas are discussed in this section.

3.1 Public health

Public health services take a leading role in improving population health outcomes and reducing inequalities in health status. Their activities involve a balance of disease prevention, health promotion and health protection programmes.

Taking the NZHS forward

- The Ministry of Health is developing the *New Zealand Public Health Strategic and Action Plan*. Fitting within the framework of the NZHS, this plan will clarify the goals, direction and strategies of the public health sector and define the role of public health service providers.
- The *Public Health Sector Project* has been established. It has put in place various strategies to connect and strengthen the public health provider sector, as well as to compile collective advice for policy makers on implementing the goals of the NZHS. A major focus has been to support discussion and provide public health sector advice to the Ministry of Health on the action strategies for the public health sector. By December 2001 the project will make recommendations for the future form and function of database and communication mechanisms.
- The Ministry of Health is developing a framework for action to reduce inequalities in health. This is supported by an overview paper on the current level of information available nationally and internationally on reducing inequalities. The intervention framework for reducing inequalities in health will be supplemented by an action pack that will detail specific initiatives that have been successfully implemented.
- The Ministry of Health is working to establish strong collaborative planning and funding mechanisms with DHBs at national and regional levels so that public health has an input into primary care. This work includes encouraging DHBs to find ways to connect with regional and district planning.
- Implementation of the Primary Health Care Strategy will include health promotion in primary health care settings.
- A number of public health initiatives address the key NZHS aim of improving population health focus. These include:
 - The *Waiora* project run by Northland DHB aims to improve water quality at marae and schools, including kōhanga reo, by improving water quality in line with the Ministry of Health's Drinking Water Strategy. The project has been discussed with 80 schools. All rūnanga in Northland and 50 widely distributed marae are participating. Thirty-five marae and 25 schools have installed water treatment and 25 schools have begun monitoring programmes to ensure that their water is safe to drink.

- *Health Promoting Schools (HPS)* has been implemented in New Zealand over the last four to five years. Recent developments have focused on improving effectiveness for Māori, integrating mental health promotion as a focus in all HPSs, development of a Health Promoting Schools Association, and continuing collaboration with the education sector. New Zealand has about 150 HPSs. The majority of other schools are also undertaking health promotion in some form.
- Regional contracts for breastfeeding advocacy and promotion have been let in Northland and Auckland. National resources to promote breastfeeding for women returning to work and for Chinese women have been developed.
- In regard to meningitis, development work is under way on a vaccine to combat a unique strain of meningococcal B disease that is running at epidemic levels in New Zealand. Over the past five years, there has been an average of 502 cases and 21 deaths per annum; since the epidemic commenced in 1991, there have been 3,800 cases and 170 deaths. A vaccine manufacturer has now been selected. It is expected that clinical trials of a new vaccine specifically developed for New Zealand will begin in 2002, which should permit mass immunisation to commence in 2004.

3.2 Primary health care

A strong primary health care system is fundamental to achieving the principles, goals and objectives of the NZHS. The Primary Health Care Strategy, launched on 1 February 2001, provides a clear direction for the future development of primary health care and sets out a new vision:

People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care.

Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.

Six key directions for primary health care will achieve this vision.

1. Work with local communities and enrolled populations.
2. Identify and remove health inequalities.
3. Offer access to comprehensive services to improve, maintain and restore people's health.
4. Co-ordinate care across service areas.
5. Develop the primary health care workforce.
6. Continuously improve quality using good information.

Primary Health Organisations (PHOs), which are to be established, will set these directions for primary care services to achieve the vision. People can enrol with a general practice or health clinic that is a PHO member. PHOs will be funded by DHBs to provide defined individual and population services to their enrolled population.

PHOs will work closely with their DHBs and their communities to identify those people who are missing out on primary health care services that could improve, maintain and restore their health, and to address their needs. As a result, primary health care services will give more attention to the population dimension of health care, actively reaching out to reduce inequalities in health status among population groups.

Taking the NZHS forward

- Much of the foundation for implementing the Primary Health Care Strategy is established. A forum group has been set up and is involved in key aspects of implementation.
- *Minimum Requirements for Primary Health Organisations* were released in November. They provide DHBs with a nationally consistent set of criteria for the qualities and qualifications of emergent PHOs.
- An expert advisory group is developing a nationwide framework for primary health care nursing.
- An expert advisory group is working on a detailed plan for successful implementation of the Primary Health Care Strategy in rural New Zealand.
- An expert advisory group is reviewing the strengths and weaknesses of the Community Services Card, along with alternative subsidy mechanisms. The group's advice will help the Government decide how its increased funding for primary health care services can best be used to reduce the cost of and other barriers to such services.

3.3 Reduced waiting times for public hospital elective services

The specific policy goals to reduce waiting times of public hospital elective services are to:

- ensure a maximum waiting time of six months for first specialist assessment
- ensure that, as part of the assessment process, patients are told one of the following:
 - they have a firm treatment date within the next six months
 - they will receive treatment within the next six months and they will be informed of the specific treatment date closer to the time
 - publicly funded treatment is not available to people with their level of need at that time; they will be cared for by their specialist and/or general practitioner, who will provide them with a plan of care.

Steady progress is evident. However, the sector has experienced some challenges in achieving the Government's objectives, including a reported growth in acute cases, which impacts on elective procedures, and some difficulties in recruiting and retaining staff.

Nonetheless, momentum within the sector continues to drive towards achieving the Government's policy objectives for elective services. Increasingly, gains from work in the primary sector will flow through to more timely specialist assessments. Likewise, as DHBs encourage integrated disease management and implement strategies to better manage acute services, resources will be more available for elective services. The secondary sector will continue to work to ensure patients receive assessment and treatment in a timely manner.

Taking the NZHS forward

- Progress toward the implementation of elective services policy in 2000/01 has been steady. Increasing numbers of patients have a plan of care and certainty of their treatment status. By 30 June 2001, only 14,477 patients remained on residual waiting lists (down from 41,544 in June 2000) without certainty or a plan of care. A number of DHBs – including Auckland, MidCentral, Otago and South Canterbury – have eliminated their residual waiting lists. A steady reduction in the national figure is expected over the next year.

The sector has worked hard to meet the national standard of a six-month maximum wait for first specialist assessment. Of all newly presenting patients in the 2000/01 year, 82.4 percent received their first specialist assessment within six months.⁶ Some DHBs achieved even more impressive results. In the region of the Taranaki DHB, for example, over 96 percent of patients received their first specialist assessment within the standard time set.

Reductions are evident in the number of patients who are assessed as eligible for publicly funded treatment but waiting longer than the six-month national standard. In 2000/01, the number of patients waiting longer than six months for treatment fell from 29,027 to 17,306.

At 30 June 2001, a total of 25,667 patients were in active review (a care pathway for patients who are just below the threshold for surgery). This number is expected to decrease as patients from residual waiting lists are reassessed. Most DHBs have implemented and are operating effective active review processes. Patients in this category receive a review of their condition at least once every six months to ensure they do not reach a state of unreasonable distress, ill health and/or incapacity.

- Of the 29 national referral and assessment guidelines, 24 have now been released for implementation. The guidelines provide a tool for prioritising patients who are seeking assessment and treatment. Once fully implemented, they will enable comparisons of financially sustainable thresholds across New Zealand to inform funding decisions and improve equity of access.

The shift to needs-based access should benefit those with a comparatively poor health status. As the guidelines are implemented and patients are treated in priority order, increased Māori access is anticipated. Preliminary data indicate that Māori are already benefiting from this shift but, as the process is ongoing, it will be some time before these gains are fully realised.

- A pilot project is underway in the Tairāwhiti region where two Māori providers are working with the DHB to improve access to elective services for hard to reach Māori. If successful, this initiative may be extended to other DHB regions.
- Work has also commenced with the primary sector to reduce the pressure on specialist assessment services. Localised guidelines for the effective management of low priority, common conditions in primary care are being developed and implemented. Work is also under way to facilitate the implementation of the national referral guidelines in primary care.
- More than 80 primary–secondary working groups around New Zealand are working to enhance primary access to diagnostics and specialist advice. To share innovations developed by these working groups, a number of national specialty forums have been held.

⁶ This figure refers to services where complete data were available.

- The establishment of general practitioner liaison positions in several DHBs is proving beneficial in strengthening primary care capacity and reducing the burden on specialist services.

3.4 Improved responsiveness of mental health services

The Government is committed to continually improving mental health services through implementing the Mental Health Commission's *Blueprint for Mental Health Services* (1998) (see Section 2.12).

To address this priority for mental health services, action is planned to:

- continue to implement the *Blueprint for Mental Health Services*
- improve the responsiveness of services for Māori
- emphasise more strongly the provision of early intervention and prevention services
- increase the focus on recovery
- improve co-ordination between the health sector and other social service sectors.

Between 1998/99 and 1999/2000 most service categories specified in the *Blueprint for Mental Health Services* grew significantly. During that time:

- an additional 802 full-time community clinical positions and 264 non-clinical positions were funded
- community clinical services for all age and specialty groups combined came to be funded to 55 percent of the *Blueprint* guidelines, general adult community services to over 80 percent, and community drug and alcohol services to about 61 percent
- expenditure on kaupapa Māori services increased by 65 percent
- community clinical services for children and youth increased by 65 percent, with 208 additional positions funded
- access to atypical antipsychotic medications exceeded the target.

Taking the NZHS forward

- The 2000 Budget allocated \$257.4 million over four years to increase and improve mental health services, giving effect to the Government's undertaking to implement the Mental Health Commission's *Blueprint for Mental Health Services in New Zealand* (1998). The additional funding allocated for 2000/01 was \$27.4 million. Funding was allocated to the following priority areas: Child and Youth; Forensic Mental Health Services; Alcohol and Drug Services; Mental Health Workforce Development.
- From 2000–2005 the Ministry of Health is investing significantly in developing the mental health workforce, supplemented by the Clinical Training Agency. In partnership with the Ministry, District Health Boards New Zealand (DHBNZ, an organisation that represents most DHBs) is helping DHBs to aggregate their staffing and training needs.
- The Māori Mental Health Strategy aims to contribute to the four pathways needed to achieve whānau ora (see Section 4.1) by promoting specific, measurable mental health objectives that complement the approach of the broader Māori health strategy. It provides the framework for development of mental health services for Māori. A draft discussion document for this strategy *Towards a National Māori Mental Health Strategy* was published in January (Ministry of Health 2001i).

- The Ministry of Health workforce plan *Tuutahitia Te Wero, Meeting the Challenges* (HFA 2000) contains about 100 separate national mental health workforce initiatives, some of which are aimed at improving co-ordination of mental health workforce development, education and training. With a particular focus on Māori and Pacific health, the plan outlines key initiatives for Māori and Pacific mental health workforce development.
- The workforce initiative *Te Rau Puawai: Workforce 100* is supporting 106 Māori students to undertake studies in mental health. Funding for initiatives to develop the Māori mental health workforce and providers increased to \$3.9 million in 2000/01. In addition, funding for Pacific mental health services increased by 51.9 percent.
- A national research and development strategy has been put in place. The Mental Health Information National Collection (MHINC) forms the core of the mental health reporting system. It is expected to serve as the main source of DHB reporting.
- The Ministry of Health, in conjunction with the New Zealand Health Information Service and the Health Research Council, has commissioned an epidemiological survey for mental health. The results, due in 2005, will provide clear information on the prevalence rates of certain mental illnesses in the population by age group and ethnicity.
- To assist individuals' recovery from mental illness and their participation in society, intersectoral linkages are being strengthened to improve access to housing of an acceptable standard, to education and to employment.

3.5 Accessible and appropriate services for people living in rural areas

The New Zealand Health Strategy acknowledges that rural New Zealanders need greater certainty of access to health services. Primary health care services are the immediate focus for the Ministry of Health as it works towards the goal of accessible and appropriate rural services. If rural communities are to gain access to sustainable 24-hour primary health care, strategies are required to successfully retain and recruit rural practitioners and to improve collaboration among rural providers.

Taking the NZHS forward

- The Primary Health Care Strategy signalled that the Ministry of Health will facilitate the development of a coherent policy and package of assistance for rural communities. The Ministry set up an expert advisory group, which met between July and November 2001, to develop a plan for implementing the Primary Health Care Strategy in rural New Zealand. The plan aims to address current problems including retention and recruitment of rural practitioners.
- The following new rural initiatives have been developed.
 - The *Rural Locum Support Scheme* is aimed at improving the retention of rural general practitioners and the sustainability of primary medical services.
 - The *Mobile Surgery Bus* was commissioned in 2001 to improve rural people's access to low-risk elective day surgery and diagnostic interventions.
 - The *Primary Response in Medical Emergencies (PRIME)* Scheme aims to ensure high quality access to medical emergency treatment for rural areas. PRIME now covers the South Island completely, along with 47 localities in the North Island.

- The Ministry of Health is piloting *Healthline*, a free 24-hour telephone triage and health advice line, in Northland, Tairāwhiti, Canterbury and the West Coast of the South Island. Two of these regions were chosen because of their large Māori populations.
- The Council of Medical Colleges of New Zealand (CMC), contracted by the Ministry of Health, conducted a review of medical and health workforce recruitment and retention in Northland, and considered the relevance of the findings to the broader provincial health services delivery network. The CMC published a report in July 2001 with a series of recommendations (Council of Medical Colleges 2001). Follow up action on the recommendations is taking place at national and local levels.

Chapter 4: Reducing inequalities

The NZHS identifies the need to reduce health inequalities for Māori, for Pacific peoples and for all people in lower socioeconomic groups. This section highlights key initiatives within each of these areas.

The Ministry of Health recognises that there is a need to have a coordinated approach to reducing inequalities in health. An intervention framework is being developed so that activities aimed at reducing inequalities can be planned and delivered in a coordinated way. The framework identifies the points of interface with other agencies, as well as the activities in the health sector that will contribute to reducing inequalities. Actions can occur at all levels, from policy-making, funding, service provision, to community action. These may be at national, regional and local level.

4.1 Reducing inequalities for Māori

Māori Health Strategy

The *Māori Health Strategy Discussion Document He Korowai Oranga* was released in April 2001 to guide progress towards achieving the Māori health objectives outlined in the NZHS.

The discussion document identifies four pathways to achieve whānau ora:

1. development of whānau, hapū, iwi and Māori communities
2. Māori participation in the health and disability sector
3. effective health and disability services
4. working across sectors.

The consultation process for the Māori Health Strategy, which included a series of 10 public consultation hui and submissions, concluded in July 2001. The final strategy is due to be completed by December 2001, then an action plan for implementation is due with Ministers by April 2002.

New Zealand Disability Strategy

The New Zealand Disability Strategy (NZDS) was launched in April 2001. It presents a long-term plan for moving New Zealand from a disabling to an inclusive society. The strategy specifically addresses issues for disabled Māori and their whānau in Objective 11, which emphasises the need to promote participation of disabled Māori.

Recently a significant step toward implementing the strategy has been made. The Māori Provider Development Scheme has provided funding to train trilingual interpreters (fluent in New Zealand Sign Language, te reo Māori and English) through the Deaf Association.

Effective Treaty partnerships

The Health Funding Authority established relationships based on the Treaty of Waitangi. These relationships will continue in the new environment. In May 2001 the Ministry of Health appointed a Māori relationships manager to assist DHBs in developing new relationships with Māori as required by the New Zealand Public Health and Disability Act 2000.

By June 2001 all DHBs had made initial moves toward establishing formal relationships with Māori in their area. Where the local community and/or DHB have requested assistance, the Ministry of Health has facilitated dialogue and information exchange to assist in the development of these relationships.

Māori providers

In January 2001 the Ministry of Health took over, from the Health Funding Authority, the funding agreements (contracts) with Māori providers. Each contract was maintained and monitored while preparations were made for its transfer to the relevant DHB. The majority of Māori provider contracts (mostly primary, community, and mental health services) were transferred to DHBs in the first quarter of the financial year 2001/2002.

Some contracts, with a total value of around \$9 million, will be transferred from the Ministry of Health to DHBs in 2002. This group of contracts includes the Treaty-based relationships agreements, new Māori provider contracts that require development and work before transfer, and contracts still under review. Māori disability support services and public health services will remain with the Ministry of Health for the time being.

All contract terms have been renewed or extended so that DHBs have time to become oriented in their new role, while Māori providers gain the opportunity to develop relationships and highlight their successes.

Māori provider development

The Māori Provider Development Scheme has just completed its fourth year of funding. In 2000/01, \$10 million was distributed among Māori providers to develop needed skills, standards and infrastructures, as well as among individuals training for health and disability professions.

Workforce development saw Māori health and disability personnel improving their skills related to health information, governance, business management, health management, clinical training, te reo and tikanga Māori. Other initiatives were taken so that Māori providers could become accredited and focus on quality and quality assurance processes.

Complementing the support for workforce development are the Māori health scholarships. In 2000/01 scholarships were awarded to 446 students, representing 97 percent of all applications received. Of the successful applicants, 16 percent were in their final year of study. Recipients included sixth and seventh form students, along with doctors, nurses, midwives, dental therapists, pharmacists and community health workers studying at undergraduate and postgraduate levels.

Other Māori workforce development initiatives have been funded from mental health and Clinical Training Agency funds (see Section 6.2).

Enhancing mainstream providers' ability to meet Māori needs and expectations

Mainstream services have begun to take greater responsibility for many aspects of Māori health. For example, publicly funded hospitals and major primary care organisations have been required (through their service agreements) to specify how they will identify and meet the needs of Māori. Most hospitals now have Māori and whānau units, which focus on ensuring that hospital services meet the needs of Māori patients effectively and address cultural safety.

Continued work on reducing inequalities will further enhance mainstream effectiveness.

Improving Māori access to services

As well as initiatives outlined in Chapter 2, further initiatives to improve Māori access to services include the following.

- *Mobile Disease State Management* is a new mobile nursing service that goes out to Māori communities, thereby improving Māori access to services for lung disease, heart disease and diabetes.
- Two pilot sites for *Intensive Home Visiting* have been selected: Tokoroa and Mangere, both of which are highly deprived. The pilots address inequalities in health status among Māori, Pacific and New Zealand European populations through a direct home visiting programme to the target population (See Section 4.3).
- *Intersectoral Community Action for Health* projects aim to improve health outcomes through intersectoral partnerships. Three such projects are operating in Kapiti, Porirua and South Auckland, while a further project is in development in Northland.
- Chapter 2 covers *Aukati Kaipāipa* (smoking cessation; Section 2.1), and *Kia Piki Te Ora o Te Taitamariki* (Youth Suicide Prevention; Section 2.5).

Taking the NZHS forward

There has been progress in the eight Māori health gain priority areas. Progress with immunisation, smoking, diabetes, mental health and oral health has been discussed in Chapter 2. Initiatives in the other three priority areas are outlined here.

Hearing

- Māori providers have been funded to purchase workforce development courses. Among the courses purchased have been local and national training programmes with tamariki ora / well child care components relevant to workforce needs. These components emphasise early detection, education, intervention and treatment of hearing impairments for tamariki.
- A plan has been developed for the implementation of the Health Funding Authority (Māori Operating Group) Report on Māori Hearing, to help improve the linkages established.

Asthma

- Asthma services to meet population needs in Taranaki have been contracted.
- The Asthma and Respiratory Foundation of New Zealand completed the *National Māori Asthma Education* plan in June 2001. The plan, which has a particular focus on tamariki Māori, is for Māori nurses, asthma educators and community workers.

Injury prevention

- In the funding approach and plan for Māori injury prevention, the following key milestones were achieved in 2000/01.
 - Training workshops for Māori injury prevention providers were held in Hamilton and Wellington.
 - The Māori caucus of the Injury Prevention Network of Aotearoa New Zealand was consolidated. The first major national injury prevention conference took place from 31 October – 2 November.
- Additional community injury prevention programmes (with significant Māori components) have been established in Wairoa, Counties–Manukau and Te Tai Tokerau. In addition, the initial pilots in Rangiora, Kawerau, Tairāwhiti and Waitakere continue to grow.
- External evaluations of the community injury prevention programmes continue to be positive. In particular, the programmes in Tairāwhiti and Waitakere have contributed to significant reductions in injury hospitalisations among Māori in those regions.

4.2 Reducing inequalities for Pacific peoples

Context

For Pacific peoples living in New Zealand, health sector changes are needed in association with improvements in education, welfare, employment, housing and other sectors. Alleviating poverty and improving the distribution of wealth in New Zealand are more likely to improve the health status of Pacific peoples than is improved care from the health sector alone (Tukuitonga 2000).

Pacific Health and Disability Action Plan

The Pacific Health and Disability Action Plan is the Ministry of Health's commitment to providing and promoting affordable, effective and responsive health and disability support services for Pacific peoples (Ministry of Health 2001j). The Ministry will work in partnership with Pacific health providers, other health sector organisations, and Pacific families and communities towards this goal.

The action plan provides health and disability support services with direction on how they can best improve the health outcomes and participation of Pacific peoples. It supports the need for a comprehensive, co-ordinated approach to achieve effective, holistic and integrated programmes within the health and disability sector.

The action plan is the culmination of extensive consultations. During 2000 the Ministry of Health undertook 17 Pacific health workshops throughout the country. Responses from these community engagements informed the development of the priority action areas within the action plan.

The Pacific Health and Disability Action Plan has the following vision:

Healthy Pacific peoples achieving their full potential throughout their lives.

This vision affirms that good health can improve life outcomes and that Pacific peoples have the right to access excellent health and disability services. It also articulates the Pacific values of service, respect and duty of care.

The principles of the action plan are that:

- for Pacific peoples, dignity and the sacredness of life are uppermost in the delivery of health and disability services
- the active involvement of Pacific peoples in all health and disability services at all levels is supported
- successful Pacific services recognise the integral roles of Pacific leadership and Pacific communities
- Pacific peoples are entitled to excellent health and disability services that are co-ordinated, culturally competent and clinically sound.

The action plan has a long-term focus. It is designed to move initiatives away from the fragmented approach that has characterised the past decade of Pacific health development.

The Pacific Health and Disability Action Plan has seven priority action areas:

1. child and youth health
2. promoting healthy lifestyles and wellbeing
3. primary healthcare and preventive services
4. health provider development
5. health workforce development
6. promoting participation of disabled Pacific peoples
7. health and disability information and research.

Each priority action area has its own goals, objectives and accountabilities, along with discussion points.

The Pacific Health and Disability Action Plan was ratified by Cabinet in October 2001.

Specific aims for Pacific health

The NZHS contains specific aims to reduce inequalities in health for Pacific peoples. Initiatives to contribute to the achievement of some of these aims are discussed in other sections of this report. This section summarises initiatives in relation to five key aims.

1. Strengthen primary health initiatives for Pacific peoples

- Initiatives under the *Pacific Provider Development Scheme* will consolidate and strengthen existing provider infrastructure, provide governance and management training and support, and increase workforce capacity and capability.
- Initiatives planned to strengthen primary health services include the development of: best practice and cultural guidelines, successful Pacific models of best care practice, strategic capability of Pacific providers, and fostering collaborative initiatives by Pacific providers and mainstream health providers.

2. Improve the health of Pacific children

- Pacific providers deliver 20 well child services throughout the country. Services include facilitation, dental services, care and support, mobile nursing, mobile hearing, and family/fanau services.
- Further services are planned to improve access to primary health care services for all Pacific children, improve uptake of immunisation and well child services, reduce the high incidence of meningococcal disease, reduce rates of intentional injuries to children, and improve antenatal care for Pacific women.

3. Improve mental health services for Pacific peoples

- *Tuutahitia Te Wero, Meeting the Challenges* (HFA 2000) outlines key initiatives for the coming year that will increase the capacity and improve the capability of Pacific mental health service provision.
- In 2000/01 the Ministry of Health increased funding for Pacific mental health services by 51.9 percent. Mental health services for Pacific peoples have been expanded both in Wellington and Auckland, increasing staff by 18.5 FTEs and funding by \$2.8 million.
- The Ministry of Health, in conjunction with the New Zealand Health Information Service and the Health Research Council, has commissioned an epidemiological survey for mental health in 2002. The results will provide clear information on the prevalence rates of certain mental illnesses in the population by age group and ethnicity.
- In some areas, culturally specific mental health services for Pacific peoples are already established. It is expected that the number of such services will increase over the next few years.

4. Enhance screening programmes to improve the health of Pacific peoples

- The Ministry of Health was involved in the co-ordination of the Pacific Wellwomen programme survey of Pacific women in the Wellington region, conducted as part of the BreastScreen Central audit. The Ministry of Health (including the National Cervical Screening Programme) and the Ministry of Pacific Island Affairs were also involved in co-ordinating the national Pacific community consultation on changes to section 74A of the Health Act 1956, to enable audit and research on Pacific women's cervical data.
- In collaboration with the National Screening Unit, the Ministry of Health is planning to develop relevant and responsive health promotion models upon which breast and cervical screening programmes can be developed and implemented.

5. Increase the number of Pacific peoples in the health workforce

- Two workforce plans are being developed: a five-year Pacific health workforce plan to be completed by 2002 and a five-year intersectoral Pacific workforce plan to be completed by 2003.
- The *Pacific Health Leadership* programme develops and strengthens leadership potential within the Pacific health workforce. Fifteen Pacific health workers have commenced the 2001 health leadership course, funding for which is being released through the Pacific Provider Development Fund.

4.3 Reducing inequalities for people in lower socioeconomic groups

Context

Regardless of whether health is measured by risk factors, use of services or outcomes, systematic inequalities in health are associated with socioeconomic status. For each socioeconomic group, their health status is worse than the next group up in the socioeconomic hierarchy.

Taking the NZHS forward

The Ministry of Health is developing a work programme to reduce inequalities in health for Māori, Pacific peoples and people on low incomes. The scope of the work covers ethnic, socioeconomic, geographic and gender inequalities. The initiatives in this programme include the following.

- A draft framework, *Reducing Inequalities in Health: An Overview*, was completed in October 2001, following consultation with government department. It was developed to assist the sector in reducing inequalities in health through intersectoral collaboration. Such collaboration will influence the social and economic determinants of health, as well as action within the health sector.
- An action pack, including best practice examples from around New Zealand, is being produced to accompany the Reducing Inequalities framework.
- The Ministry of Health produced two additional resources in 2001: *Monitoring Ethnic Inequalities in Health* (Ministry of Health 2001k) and *Indicators of Inequality: Classification and Selection of Ethnic Health Disparity Indicators* (Ministry of Health 2001l).
- The programme *Intersectoral Community Action for Health* aims to improve health outcomes through intersectoral action, combining a wide range of expertise and commitment to mobilise communities and extend primary care access. Programmes have been established in Porirua, Kapiti, South Auckland and Northland.
- The *Healthy Housing Programme* in South Auckland is a joint programme of Housing New Zealand, Counties–Manukau DHB and Auckland DHB. Its main objective is to reduce overcrowding in Mangere, Otara and Onehunga; these areas were chosen because of their high rates of meningococcal disease (which is correlated with other diseases). The project aims to assess and improve health and social services for 650 homes by the end of June 2002.

- The *Better Homes Project* is a joint initiative of Taranaki Energy Trust, the Ministry of Health, the New Plymouth City Council, the Department of Labour and the Energy Efficiency Conservation Authority. The aim is to quantify the impacts of inadequate housing on health, as well as to reduce those impacts by improving housing conditions. The programme covers 100 low-income homes in Waitara, a community with high levels of unemployment and a significant Māori population. The project was established in early 2000 and the final report is expected in January 2003.
- The use of the Community Services Card as a mechanism to deliver subsidies for primary care services for low-income people is being reviewed. Concurrent work is focusing on the funding and delivery of the primary care strategy and the review of future funding of health services.
- An *Intensive Home Visiting* initiative has been established to deliver services to populations with high needs. Tokoroa and Mangere, both low-income communities with high proportions of Māori and Pacific peoples, have been selected as pilot sites. The purpose of the Home Visiting Service is to assess health needs, and to provide information, health education, community support, advocacy, and assist with access to existing services. The Ministry of Health is working towards having services up and running in both areas early next year.

Chapter 5: Ensuring quality services

This section outlines key mechanisms and principles that will help ensure the quality of the services contributing to the achievement of NZHS objectives. Specifically, it covers quality improvement, individual rights, co-ordination and consultation.

5.1 Quality improvement

To implement the fundamental NZHS principle of a high-performing health system in which people have confidence, it is critical to ensure quality of services. Work in this area has focused on identifying and introducing mechanisms that enable the right services to be delivered in the right way with the right results, and that minimise adverse events. Moreover, as every aspect of the system has a quality dimension, everyone in the sector can contribute to meeting this goal.

The health and disability sector, which includes the District Health Boards and the Ministry of Health, has worked on a range of quality enhancement projects that establish the foundations from which the Government can achieve its objective for the performance of the health system. Initiatives have been developed to:

- develop sector-wide agreement on the approach to quality
- enhance the regulatory environment
- strengthen accountability
- create opportunities for shared learning and improved co-ordination
- provide supportive infrastructure.

Key initiatives in the above areas include:

- The National Health Committee released a discussion document on quality improvement in the health system in September 2001.
- Work to enhance the regulatory environment includes:
 - the Health Professionals' Competency Assurance Bill, scheduled for introduction to Parliament early in 2002
 - the Health and Disability Services (Safety) Bill, which is currently going through the Parliamentary process
 - the policy work required to introduce legislative changes that respond to the *Report of the Ministerial Inquiry into the Under-reporting of Cervical Smear Abnormalities in the Gisborne Region* and the independent *Review of Processes Concerning Adverse Medical Events* and the *1999 Review of the Health and Disability Commissioner Act 1994*. This work is now complete and it is planned that a Bill will be introduced shortly.
- An initial set of DHB accountability indicators, reflecting the priorities and goals of the NZHS, have been developed.
- The Ministry of Health has supported forums to advance quality. For example, during the Quality in Health Week in September 2001, workshops on improving quality in health were held. These workshops brought together many individuals in the sector to focus on learning how to identify and improve quality. Dr Don Berwick (President and CEO of the Institute for Healthcare Improvement in the US) provided expert input to these workshops.

5.2 Individual rights

The rights contained within the NZHS remain fundamental and available to all individuals in New Zealand. These include rights under the Privacy Act 1993 and the Health and Disability Commissioner Act 1994.

Because the government exemption from the Human Rights Act 1993 ends on 31 December 2001, human rights legislation has been examined across all government sectors this year. Recent decisions by the Government have indicated that, within the area of anti-discrimination, the New Zealand Bill of Rights Act 1990 will become the standard. The Government is looking at a new institutional framework for human rights in New Zealand.⁷

5.3 Co-ordination

One of the key themes of the NZHS is co-ordination, both among different groups within the health sector and between the health sector and other sectors such as housing and education. Individuals and groups should, as far as possible, experience seamless care. Linkages with other sectors are also important because of their role in determining health.

Since the launch of the NZHS, the Ministry of Health has taken the following initiatives to improve co-ordination:

- *Toolkits*, as discussed in Chapters 1 and 2, have been developed for DHBs. They include consideration of intersectoral collaboration and co-ordination for each of the 13 priority population health areas.
- Several other strategies produced by the Ministry of Health address co-ordination. These include the *Primary Health Care Strategy*, the *Māori Health Strategy* and the *Pacific Health and Disability Action Plan*.
- The Ministry of Health has been working on the *Intersectoral Community Action on Health* project with a number of sectors and organisations. This project aims to improve co-ordination among a number of different agencies with an interest in health. The pilot sites are located in South Auckland, Porirua, Otaki and Northland. Results from these pilots will be made available to DHBs.
- The Ministry of Health is developing a guide to national agencies, which lists government agencies with an interest in health as well as major national health organisations.⁸

In addition to their participation in these national initiatives, DHBs are working across their boundaries and with other agencies to ensure co-ordination within the health sector and between health and other sectors. DHBs are responsible for ensuring coordination of services within their districts. DHBs have already set up a number of Shared Service Agencies to provide technical assistance in activities such as needs assessment, and epidemiological and economic analysis.

Other national agencies will assist in providing national consistency. For example, Pharmac, the national agency that runs the pharmaceutical schedule, is starting to work with DHBs to encourage national consistency in pharmaceutical purchasing. At a local level the health needs assessment, undertaken by each DHB, will provide a comprehensive view of the different agencies that impact on health in each DHB region. DHBs are also collaborating on needs assessment methodologies.

⁷ More information can be found at the Ministry of Justice web site at <http://www.justice.govt.nz>

⁸ This guide will be available at the Ministry of Health web site at <http://www.moh.govt.nz>

5.4 Consultation

The Public Health and Disability Act requires DHBs to consult with their resident populations on the significant aspects of district strategic plans before determining or amending them; the plans have a 5- to 10-year focus.

The Ministry of Health has provided DHBs with advice in this area during the development of their capability. For instance, five consultation workshops held in May 2001 were well attended by representatives from all DHBs.

Many DHBs have already commenced their strategic planning processes, factoring in consultation with their resident populations. These processes are incorporating information to be contained in the Ministry of Health's consultation guidelines, a draft of which has been provided to the DHBs.

All DHBs have:

- formalised their partnership with Treaty partners at a governance level
- developed the necessary consultation capability, including appointment of appropriate people to DHBs and relevant shared support agencies
- established the required statutory committees (community and public health advisory committee, disability support advisory committee and hospital advisory committee)⁹ and engaged the relevant communities in this work.

⁹ New Zealand Public Health and Disability Act 2000

Chapter 6: Investing in the future

Investing in the future requires attention to information management and technology, workforce development and an appropriate evaluation of health sector changes, including NZHS implementation. These issues are explored in this section.

6.1 Information management and technology

Health sector reforms, the shift toward integrated, evidence-based care and rapid advances in technology have made it necessary to update the health information strategy. During 2000 the Ministry of Health produced a draft Health Knowledge Strategy and, to build on this draft, in December established a programme of activity, the Working to Add Value through E-information (WAVE) programme.

An independent advisory board, chaired by Hon David Caygill, was appointed by the Director-General of Health to oversee the activities of the project and ensure that sector interests were represented.

WAVE was supported by a small core team of staff from the Ministry of Health and the health and disability sector. It contained eight streams: data standards, systems, investment, electronic health records, privacy, knowledge, organisation design and strategy.

A national submission process was also conducted to solicit input from the sector; simultaneously, the draft Knowledge Strategy was sent out for discussion and comment. WAVE's primary objectives were to design a three- to five-year plan for:

- an information infrastructure to support patient-centric integrated care
- a governance structure for information management and technology to ensure national coherence and consistency.

The resulting report *From Strategy to Reality* was launched on 29 October 2001. The Report made 79 recommendations aimed at improving the quality of information management and ultimately the quality of health care for New Zealanders.

At the launch of the WAVE report, the Minister announced the establishment of Working Group to examine the implications involved in establishing a non-statutory Health Information Standards Organisation. The group, which is formally known as the Ministerial Committee on Health Information Standards Organisation, is tasked with reviewing the direction national standards should take and with identifying the priority issues that should be addressed. The group has a timeframe of six months to report, but the Chair, the Hon. David Caygill, anticipates being able to provide an initial report early next year.

6.2 Workforce development

Two key initiatives are under way to ensure the health workforce is appropriately trained to meet the objectives of the NZHS.

The Health Workforce Advisory Committee (HWAC) has been established this year to take a strategic overview of the workforce and advise the Minister accordingly. HWAC held its first meeting in May 2001. Its work programme has been agreed with the Minister of Health. A

stock-take on the current situation in the health workforce, which will involve extensive consultation, will be presented to the Minister by the end of the year.

The Health Professionals' Competency Assurance Bill is scheduled to be introduced to Parliament early in 2002. It will establish a framework that permits flexibility and innovation in the workforce, while regulating all health professionals where there is a risk of harm to the public. It will repeal the 11 existing regulatory statutes.

Taking the NZHS forward

- District Health Boards New Zealand (DHBNZ) and the Ministry of Health have signed a \$1.2 million contract to improve recruitment, retention and training in the mental health workforce.
- In regard to developing the Māori health workforce, the Clinical Training Agency is introducing health training and education programmes in 2001/02 designed to reduce Māori health inequalities. These programmes are the Rongō Māori programme, the Hauora Māori National Certificate and Diploma programmes, general practice rural rotation placement programme, the Māori Child and Family Health Certificate and Hauora.com, a capacity building organisation.
- The Ministry of Health is working on a variety of initiatives regarding community nursing support. For example, it is working with nursing organisations to develop the role of nurse practitioner, assisting DHBs to effectively implement this role, and working with DHBs and nursing organisations on a collaborative project to develop strategies for the recruitment and retention of nurses.
- Recognising the impact of advances in technology, the Ministry of Health will work with the Tertiary Education Commission to ensure that the tertiary education system is producing health practitioners with the necessary skills to deliver the health services of the future.

6.3 Evaluation

Planning is under way for a three-year evaluation of the changes resulting from the New Zealand Public Health and Disability Act 2000. Jointly funded by the Government and the Health Research Council, it will be an independent research project co-ordinated by the Health Services Research Centre in Wellington.

A major focus will be on the role of DHBs in achieving Government objectives. The evaluation will address the implementation of the NZHS, along with related strategies and policy initiatives such as improved services for Māori and Pacific peoples, the New Zealand Disability Strategy and Primary Health Care Strategy.

The evaluation includes a formative element. There will be feedback sessions with DHBs, key government agencies and other health care providers. The lessons learnt from the evaluation will help DHBs and others to achieve government objectives. Some intermediate outcomes, for example, changes in funding or availability of services relating to improved services for Māori, will be monitored.

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