The New Zealand Health Strategy

Discussion Document

Hon Annette King
Minister of Health

June 2000
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>v</td>
</tr>
<tr>
<td>How to Have Your Say</td>
<td>vi</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>xiii</td>
</tr>
<tr>
<td>Chapter 1: Introduction</td>
<td>1</td>
</tr>
<tr>
<td>The development of the New Zealand Health Strategy</td>
<td>1</td>
</tr>
<tr>
<td>Structure of the Strategy document</td>
<td>2</td>
</tr>
<tr>
<td>How does the New Zealand Health Strategy fit with other strategies?</td>
<td>2</td>
</tr>
<tr>
<td>The New Zealand Health Strategy: where to from here?</td>
<td>2</td>
</tr>
<tr>
<td>Chapter 2: Why Change?</td>
<td>3</td>
</tr>
<tr>
<td>Why change? – To address the determinants of health</td>
<td>3</td>
</tr>
<tr>
<td>Why change? – To implement comprehensive programmes</td>
<td>4</td>
</tr>
<tr>
<td>Why change? – To address disparities in health</td>
<td>5</td>
</tr>
<tr>
<td>Chapter 3: Fundamental Principles</td>
<td>6</td>
</tr>
<tr>
<td>Chapter 4: Goals and Objectives</td>
<td>8</td>
</tr>
<tr>
<td>Goals, objectives and targets</td>
<td>8</td>
</tr>
<tr>
<td>Why have goals and objectives?</td>
<td>8</td>
</tr>
<tr>
<td>History of goal-setting in New Zealand</td>
<td>8</td>
</tr>
<tr>
<td>How will they work?</td>
<td>8</td>
</tr>
<tr>
<td>How are they chosen?</td>
<td>9</td>
</tr>
<tr>
<td>Structuring goals and objectives</td>
<td>9</td>
</tr>
<tr>
<td>Goals and objectives to address social inequalities in health</td>
<td>10</td>
</tr>
<tr>
<td>A sector-wide approach to improving population health</td>
<td>10</td>
</tr>
<tr>
<td>Reducing health disparities for Māori</td>
<td>13</td>
</tr>
<tr>
<td>Priority areas in population health</td>
<td>14</td>
</tr>
<tr>
<td>Chapter 5: Service Priorities</td>
<td>17</td>
</tr>
<tr>
<td>Public health</td>
<td>17</td>
</tr>
<tr>
<td>Primary health care</td>
<td>17</td>
</tr>
<tr>
<td>Reducing waiting times for public hospital elective services</td>
<td>18</td>
</tr>
<tr>
<td>Improving the responsiveness of mental health services</td>
<td>19</td>
</tr>
<tr>
<td>Māori advancement in health</td>
<td>20</td>
</tr>
<tr>
<td>Improving Pacific people’s health</td>
<td>21</td>
</tr>
</tbody>
</table>
The New Zealand Health Strategy focuses on improving the health of New Zealanders. In this country we have a strong health system based upon the hard work, dedication and commitment of those working within the sector. The Government feels, however, that this hard work has been hampered by the commercial focus of health care in recent years. It is clear that, despite improvements in health status, New Zealand is slipping behind other developed countries. This is particularly evident in the Māori and Pacific peoples’ communities. Behind the statistical comparisons lies the unacceptable reality that some New Zealanders live in unhealthy housing, have poor nutrition and, in rural areas, have limited access to clean water and sewerage systems.

Despite the commitment of those working in the sector, some members of the public have lost their trust in the health system. They are no longer confident that they will be cared for when they are ill, or will have adequate support if they have a disability.

These are the issues that this Strategy sets out to address. This Government is committed to working together with the health sector, and other sectors, to tackle these problems, despite the difficulties involved. This Strategy calls for the health sector to work co-operatively towards common goals, rather than competing for the largest share of the health dollar. Our combined goals must be the improvement in the health of our community, reduced disparities in health outcomes among Māori and also among Pacific peoples, and the highest quality care for people who are sick or disabled, within the money available.

The New Zealand Health Strategy sets the direction for action on health by providing a unifying nationwide framework within which the health sector will develop. It places emphasis on improving population health outcomes, reducing disparities in health status between population groups, and addressing Treaty of Waitangi issues. It also addresses the issue of access to hospital services, and lends further support to the development of mental health services.

This discussion document is for consultation with the sector and the wider public prior to a final document being published. I encourage you to respond, and the first pages of the document discuss how you may do this.

Hon Annette King
MINISTER OF HEALTH
How to Have Your Say

This discussion document is being widely distributed among health services providers, health consumer groups, community organisations, non-governmental organisations, government agencies, other organisations and individuals interested in health issues.

You can provide comments in a number of ways:

- attend one of these public meetings:
  - 26 June 2000 (Monday), 7.00 pm – 8.30 pm
    Invercargill Workingmen’s Club
    154 Esk Street
    INVERCARGILL
  - 26 June 2000 (Monday), 3.30 pm – 5.00 pm
    Quality Hotel
    9 Riverside Drive
    WHANGAREI
  - 27 June 2000 (Tuesday), 12.15 pm – 1.45 pm
    Copthorne Hotel
    196–200 Quay Street
    AUCKLAND
  - 27 June 2000 (Tuesday), 7.00 pm – 8.30 pm
    Bruce Mason Centre
    Cnr Hurstmere Road and The Promenade
    TAKAPUNA
  - 27 June 2000 (Tuesday), 12.15 pm – 1.45 pm
    Dunedin Hospital
    Colquon Theatre
    1st Floor
    Great King Street
    DUNEDIN
  - 27 June 2000 (Tuesday), 7.00 pm – 8.30 pm
    Grovenor Hotel
    26 Cains Terrace
    TIMARU
  - 28 June 2000 (Wednesday), 7.00 pm – 8.30 pm
    Avondale Racecourse
    Ash Street
    AVONDALE
  - 28 June 2000 (Wednesday), 7.00 pm – 8.30 pm
    Westpac Trust Canterbury Centre
    Cnr High and Cashel Streets
    CHRISTCHURCH
  - 29 June 2000 (Thursday), 7.00 pm – 8.30 pm
    Quality Kings Hotel
    32 Mawhero Quay
    GREYMOUTH
– 29 June 2000 (Thursday), 7.00 pm – 8.30 pm
Albany Park Motor Inn
477 Great South Road
MANUKAU

– 5 July 2000 (Wednesday), 12.15 pm – 1.45 pm
Copthorne Resort Hotel
High Street South
MASTERTON

– 5 July 2000 (Wednesday), 12.15 pm – 1.45 pm
Avenue Motor Inn
379 Victoria Avenue
WANGANUI

– 6 July 2000 (Thursday), 12.45 pm – 1.45 pm
Copthorne Rutherford Hotel
Riwaka Room
Trafalgar Square
NELSON

– 6 July 2000 (Thursday), 12.15 pm – 1.45 pm
Plymouth International
Cnr Courtney and Leach Streets
NEW PLYMOUTH

– 11 July 2000 (Tuesday), 7.00 pm – 8.30 pm
Quality Hotel
100 Garnett Avenue
Te Rapa
HAMILTON

– 12 July 2000 (Wednesday), 12.15 pm – 1.45 pm
Rotorua Convention Centre
1170 Fenton Street
ROTORUA

– 12 July 2000 (Wednesday), 3.30 pm – 5.00 pm
Kiwi Fruit Country
Young Road
TE PUKE

– 13 July 2000 (Thursday), 12.15 pm – 1.45 pm
War Memorial Hall
48 Marine Parade
NAPIER

– 13 July 2000 (Thursday), 7.00 pm – 8.30 pm
Sandown Park Hotel
Childers Road
GISBORNE

– 19 July 2000 (Wednesday), 12.15 pm – 1.45 pm
West Lounge
Level 2
Westpac Trust Stadium
Waterloo Quay
WELLINGTON
– 19 July 2000 (Wednesday), 7.00 pm – 8.30 pm
Angus Inn
Cnr Bloomfield Terrace and Cornwall Street
LOWER HUTT

– 20 July 2000 (Thursday), 12.15 pm – 1.45 pm
Quality Hotel
110 Fitzherbert Avenue
PALMERSTON NORTH

Hui

– 1 June 2000 (Thursday), 9.00 am – 4.00 pm
The Park Lodge on Pahia
Cnr Seaview and McMurtry Roads
Pahia
BAY OF ISLANDS

– 2 June 2000 (Friday), 9.00 am – 4.00 pm
Lakeside Convention Centre
Montgomerie Road
Airport Oaks
Mangere
AUCKLAND

– 14 June 2000 (Wednesday), 9.00 am – 4.00 pm
Wanganui Function Centre
Purnell Street
WANGANUI

– 21 June 2000 (Wednesday), 9.00 am – 4.00 pm
Akona Te Rangatahi Trust
73 Stone Street
Kaikorai Valley
DUNEDIN

– 22 June 2000 (Thursday), 9.00 am – 4.00 pm
Rehua Marae
79 Springfields Road
St Albans
CHRISTCHURCH

– 23 June 2000 (Friday), 9.00 am – 4.00 pm
Omaka Marae
Aerodrome Road
BLENHEIM

– 29 June 2000 (Thursday), 9.00 am – 4.00 pm
Kohupatiki Marae
Between HASTINGS and NAPIER

– 6 July 2000 (Thursday), 9.00 am – 4.00 pm
Plymouth International
Cnr Courtenay and Leach Streets
NEW PLYMOUTH

– 12 July 2000 (Wednesday), 9.00 am – 4.00 pm
Whakatane Sports and Cultural Centre
WHAKATANE
• or make a written submission on your own behalf or as a member of an organisation. A series of questions that you may want to use to guide your response is given below.

Comments on any aspect of this document are welcomed. If you do not want to comment on some questions you do not need to.

It would help the analysis of the submissions if you present your comments with reference to the questions asked and/or the specific chapters of the discussion document.

If you are making a submission on behalf of an organisation, please describe the organisation and its interest in health provision, identify your position within the organisation, and indicate the extent of any consultation or discussion you have undertaken. If you are making an individual submission, please indicate any connection you have to health (for example, as a patient or services provider).
You can provide comments by e-mail, or through our Internet site (see below).

All submissions received will be available under the Official Information Act 1982.

Submissions should be sent to: NZHS Consultation
Policy Group
Ministry of Health
PO Box 5013
WELLINGTON
fax: (04) 496 2342
e-mail: nzhs@moh.govt.nz

This document is also posted on the Ministry of Health web site. Submissions can be made via the Internet: www.moh.govt.nz/nzhs.html

The closing date for receipt of submissions is **5 pm on Friday 28 July 2000.**

Please contact Angela O’Connor at the Ministry of Health if you have any queries. Angela can be contacted by mail at the address above, by phoning (04) 496 2208, faxing (04) 496 2340 or by e-mailing angela_o’connor@moh.govt.nz.
Question 1

This document proposes that a set of important principles be used to guide the future development of the health sector.

Please comment on this proposal. For example, do you agree with the idea that a set of principles should guide the development of the health sector? Do you think that the principles suggested are appropriate? Do you think that other principles should be added or replaced?

Question 2

This paper proposes a number of population goals and objectives to guide action on improving the health of the community, and reducing differences in health status between population groups.

Please comment on this proposal. For example, do you think that these goals and objectives provide a useful guide for action to improve the health of New Zealanders? Are they important? Do you think that other goals and objectives should be added or substituted?

Question 3

This paper proposes 12 priority objectives for immediate action by the health sector, District Health Boards and the Ministry of Health.

Please comment on this proposal. For example, is this a useful approach? Do you agree on the choice of issues? Should other objectives be substituted or added? Why?

Question 4

This paper proposes improving access to public health services, primary health care services, public hospital elective services and mental health services in the short to medium term, as well as prioritising services for Māori and Pacific peoples.

Please comment on this proposal. For example, is it important to improve access to these services? Do you think there are particularly important issues that need to be addressed in these areas? Are there other services that you think need to be improved in the short to medium term?

Question 5

This paper identifies key criteria that service providers should meet to ensure that the health system is working properly.

Please comment on this proposal. For example, do you agree on the need for nationally consistent criteria? Are these the right criteria or would you add or substitute others? How should these criteria be specified?
Question 6

This paper proposes that health services need to be better co-ordinated to improve access.

Please comment on this proposal. For example, do you agree that health services need to be better co-ordinated? How would you recommend that this process be achieved?

The following questions apply to the future process for developing and implementing stage 2 of this strategy and, in particular, methods for consultation.

Question 7

What do you think are the most effective ways for you and your community or organisation to be involved in future consultation at either a central level or a District Health Board (local) level? For example, methods might include public meetings, small groups, meetings, hui, fono or making written submissions.

Question 8

What is the best way for District Health Boards and/or the Ministry of Health to provide you with information to help you make informed comment? For example, methods might include leaflets, community meetings, web-site information.

Question 9

There are a large number of issues that the Ministry of Health or the District Health Boards might consult on each year. What issues do you think it is most important that the public be consulted on? How would you like the Ministry of Health or the District Health Boards to decide on which these will be?
Executive Summary

This discussion document addresses Stage 1 of the New Zealand Health Strategy and sets the platform for the Government’s programme of change. It identifies the Government’s priority areas. It aims to ensure that health services are directed at those areas which will ensure the highest benefits for our population, focusing in particular on tackling inequalities in health. It addresses both ‘goals and objectives’ and ‘service priorities’.

The New Zealand Health Strategy identifies seven fundamental principles which should be reflected across the sector. Any new strategies or developments that are carried out should relate to these seven principles. The principles are:

**Principle 1:**
Very good health and wellbeing for all New Zealanders throughout their lives.

**Principle 2:**
An improvement in health status of those currently disadvantaged.

**Principle 3:**
Collaborative health promotion and disease and injury prevention by all sectors.

**Principle 4:**
Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay.

**Principle 5:**
Acknowledging the special relationship between tangata whenua and the Crown under the Treaty of Waitangi.

**Principle 6:**
A high-performing system in which people have confidence.

**Principle 7:**
Active involvement of consumers and communities at all levels.

In developing the New Zealand Health Strategy a process was undertaken to highlight key goals and objectives. The goals and objectives were chosen according to a variety of criteria including, crucially, the degree to which they could improve the health status of the population and their potential for reducing health inequalities.

Out of a total of nine goals and 50 objectives the Government has highlighted 12 objectives for the Ministry of Health and District Health Boards to focus upon for immediate action. The 12 objectives are shown overleaf:
Objectives for immediate action:

- To address the health disparities between Māori, Pacific peoples and other New Zealanders
- To reduce smoking
- To improve nutrition and reduce obesity
- To increase the level of physical activity
- To reduce the rate of suicides and suicide attempts
- To minimise harm caused by alcohol, illicit and other drug use to both individuals and the community
- To reduce the incidence and impact of cancer
- To reduce the incidence and impact of cardiovascular disease
- To reduce the incidence and impact of diabetes
- To improve oral health
- To reduce violence in interpersonal relationships, families, schools and communities
- To ensure appropriate child health care and immunisation services.

In addition to the above 12 objectives the New Zealand Health Strategy highlights six service delivery areas the Government wishes the health sector to concentrate upon in the short to medium term. The six service priority areas are shown below:

Service priority areas:

- Public health
- Primary health care
- Reducing waiting times for public hospital elective services
- Improving the responsiveness of mental health services
- Māori advancement in health
- Improving Pacific people’s health.

The discussion document also looks at issues around the delivery of high-quality health services through a high-performing system and the implications of this.

This discussion document reflects Stage 1 of the New Zealand Health Strategy. Stage 2 will reflect the more established nature of District Health Boards which will have developed close community and intersectoral links. Stage 2 will be an ongoing process to add new components to the New Zealand Health Strategy. It will provide further guidance to District Health Boards on key issues. It will also allow them more flexibility to respond to the needs of their local populations.

The discussion document requests feedback on the document itself (Stage 1), and also on the processes by which the Strategy can be augmented in the future (Stage 2).
Chapter 1: Introduction

The New Zealand Health Strategy Discussion Document sets the platform for the Government’s programme of change. Understanding the factors that determine health and how to influence them positively is key to making a difference.

The New Zealand Health Strategy Discussion Document identifies the Government’s priority areas. It aims to ensure that health services are directed at those areas that will ensure the highest benefits for our population, focusing in particular on tackling inequalities in health. It addresses goals and objectives as well as service priorities.

The development of the New Zealand Health Strategy

The New Zealand Health Strategy will be developed in two stages. Stage 1 will establish the overall framework for the sector, as well as the priority areas that the Government expects District Health Boards and all those working in the health sector to address. This will form the working environment for District Health Boards and will be reflected in Funding Agreements between them and the Minister of Health. These agreements will also contain specific detail regarding non-discretionary ongoing service delivery, to ensure comprehensive coverage.

Stage 2 will reflect the more established nature of District Health Boards, which will have developed close community and intersectoral links. The Ministry of Health will carry out further work to identify how priorities can be addressed by District Health Boards, while allowing for local flexibility to meet local needs. ‘Toolkits’ will, for example, be developed to help District Health Boards address priority health objectives. Thus Stage 2 will be an ongoing process providing further guidance to District Health Boards on key issues.

The Government values the diverse expertise and experience that exists within the health sector. This first draft of the New Zealand Health Strategy, which addresses Stage 1 of the process, has been developed with the input of a Sector Reference Group, made up of consumers and providers from different parts of the health sector. This group has been advising the Ministry of Health on the development of the Strategy and the consultation around it.

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1 ‘Intersectoral’ refers to the links between the health sector and other government portfolios or sectors, such as education, housing, income support and employment.

2 Ownership of the New Zealand Health Strategy rests with the Minister of Health.
In addition, an Expert Advisory Group has provided specific advice to the Ministry of Health on the Government’s health goals, objectives and targets for inclusion in the draft New Zealand Health Strategy.

Appendix 1 lists the members of the Sector Reference Group and the Expert Advisory Group.

**Structure of the Strategy document**

This document has four main sections:

- **fundamental principles** – the underlying principles for the health sector. These provide the framework within which the sector will move forward, and are considered in Chapter 3
- **population health goals and objectives** – aimed at improving the health of New Zealanders and reducing inequalities (Chapter 4)
- **service priorities** – aimed at ensuring that New Zealanders have timely access to six priority services (Chapter 5)
- **implementation issues** – important issues that need to be addressed in implementing the Strategy and ensuring a high-performing health sector (Chapter 6).

**How does the New Zealand Health Strategy fit with other strategies?**

The New Zealand Health Strategy provides an overarching strategy for the health sector. It sits alongside the New Zealand Disability Strategy, currently in development, which addresses disability issues.

The New Zealand Health Strategy does not replace existing, specific health strategies, such as the Child Health Strategy, the National Mental Health Strategy and the recently released draft strategy addressing primary health: *The Future Shape of Primary Health Care*. These fall under the New Zealand Health Strategy umbrella. The aim of the New Zealand Health Strategy is to set priorities, to provide a focus for existing strategies, and to create a framework for future strategy development.

The health sector contributes to important intersectoral strategies on issues such as road safety, environmental health, biosecurity, support for disadvantaged families, and youth suicide. This contribution will also fall under the umbrella of the New Zealand Health Strategy, and will continue to be extended and developed in association with other agencies.

**The New Zealand Health Strategy: where to from here?**

In the next phase of development of Stage 1 of the New Zealand Health Strategy, the Government is seeking the input of the wider health sector and the New Zealand public through a consultation process.

Once the responses from the consultation process have been analysed and taken into account, the Government will finalise the New Zealand Health Strategy (Stage 1) and it will be released to the sector and the public.

As outlined above, the New Zealand Health Strategy is intended to be a ‘living’ document which will build on good initiatives and developments in the health sector. It will therefore be revised at intervals to take account of new changes and to incorporate additional specific strategies.
Chapter 2: Why Change?

The Government is reconfiguring the health and disability sector to improve the overall health status of New Zealanders. The introduction of District Health Boards will help to ensure that services reflect the needs of individuals and communities at a local level. Local decision-making will also help to deliver the Government’s commitment to reduce inequalities and improve health status. District Health Boards will be responsible for the health of their local populations.

The changes will:

• focus on population needs
• reduce disparities in health
• emphasise community and consumer involvement at all levels
• improve co-ordination across the health sector so that the whole system works for people
• ensure healthy public policy implementation across all government portfolios and sectors
• achieve a non-commercial, collaborative and accountable environment that encourages co-operation on common goals
• create an environment where those working in the sector feel part of the total system.

More detail on the actual roles and accountabilities of the changed structures is given in Appendix 2 to this document.

Why change? – To address the determinants of health

The changes being implemented allow us to consider and begin to address the determinants of health. Given the aim of improving the health of the population, there is a need to focus on those factors that have the most influence on our health. These factors are complex and range from socioeconomic variables to individual factors such as age and genetic inheritance. Determinants of health interact in many ways, and addressing one will have an impact on others.

Tackling the broader determinants requires action across sectors. Often the lead for work at these levels comes from outside the health sector, for example in housing and employment.

The health sector has a key role in encouraging and supporting action in other sectors, including identifying and advising on the health impact of policies and trends occurring there.

There is clear international evidence that the key determinants of health include:

• age
• gender
• ethnicity
• income
• education
• employment
• housing
• a sense of control over life circumstances
• access to health care services.

Strong relationships have been identified between poor health status and factors such as low income, income inequalities, poor housing, low educational achievement and unemployment. The health sector plays a key role, as recent work such as Our Health, Our Future (Ministry of Health 1999b) demonstrates. There is the potential to reduce health inequalities through an improved focus on prevention and management of chronic diseases and their disabling consequences, especially by using health promotion approaches and primary care programmes.

In New Zealand there is increasing recognition of the importance culture has as a determinant of health. The connection between culture and wellness is most clearly depicted by the Māori definition of health. For example, the Whare tapa whā (Durie 1994) Māori health model, which is also known as the four cornerstones of Māori health, describes four dimensions that contribute to wellbeing: te taha wairua (spiritual aspects), te taha hinengaro (mental and emotional aspects), te taha whānau (family and community aspects), and te taha tinana (physical aspects). Good Māori health is dependent upon the equilibrium of these dimensions. Explicit recognition of culture as a determinant is therefore an important component of effective strategy, policy and practice for Māori health gain and development in New Zealand’s health sector.

Effective action relies heavily on strong and effective relationships at central and local levels. Although many good relationships already exist, these can be widened and strengthened. Key relationships are those within and between:

• the public
• the public health components of the health sector
• the personal health and disability support components of the sector
• other sectors of society such as government agencies, local government and local community groups.

Sound partnerships based on the Treaty of Waitangi are required at all levels of the health sector. The aim of these partnerships is not only to improve Māori health gain and development but also to ensure that each partner is proactive and jointly responsible for improving Māori health. The many good relationships that already exist need to be consolidated and grown with a view to ensuring that the new structural changes continue to contribute to reducing health inequalities.

**Why change? – To implement comprehensive programmes**

A comprehensive approach enables co-ordinated, holistic, robust programmes which build on work in other areas and ensure effective use of limited resources. Comprehensive programmes will:

• focus on the settings and social context in which people live, work, learn and play
• foster Māori development and enhance mainstream services
• focus on key population health issues
• address the needs of Pacific peoples and facilitate their development
• bridge the interface between public health, personal care (both primary and secondary) and long-term care, to deliver co-ordinated disease prevention and health promotion services from the personal health, public health and disability support components of the sector

• employ public health approaches across sectors. (Note that these strategies are often led, developed and implemented by other agencies in consultation with the Ministry of Health, for example, injury prevention work carried out by the Land Transport Safety Authority, ACC, the Police, and Occupational Safety and Health (OSH).)

Why change? – To address disparities in health

| Making a difference: closing the gaps for Māori and Pacific peoples |

Many people with higher health needs do not access the types of services they require. This is particularly evident among Māori and Pacific peoples and may be due to financial or geographic barriers, or cultural reasons.

The Government has given priority to reducing the disparities in social and economic outcomes for Māori and Pacific peoples in New Zealand and a work programme is in place to ensure identifiable progress is made over the next three years to reduce these disparities. This work programme has been called Closing the Gaps.

Addressing health inequalities is a major priority requiring ongoing commitment across the sector and involves work in three broad areas:

• public sector reform
• capability building
• specific sector initiatives.

In order to design policies and programmes to ‘Close the Gaps’, the Ministry of Health and District Health Boards will:

• identify community-driven initiatives that are either achieving results for Māori and Pacific peoples or that have the potential to do so
• identify ways they can respond to communities’ needs and interests
• advise communities and provide them with information to help them meet their needs and fulfil their interests
• help communities to access the optimum mix of resources to achieve their own goals
• adapt policies, programmes and funding to support successful community initiatives
• implement programmes identified in the intersectoral Closing the Gaps initiative as this develops, in order to address health inequalities
• liaise with other government agencies on a national and local basis to build more co-ordinated policies and programmes
• focus on results.
Chapter 3: Fundamental Principles

The New Zealand Health Strategy is based on seven underlying principles that the Government sees as fundamental. These principles are to be applied across the sector and should be reflected in any new strategies or developments.

**Principle 1:**
Very good health and wellbeing for all New Zealanders throughout their lives.

**Principle 2:**
An improvement in health status of those currently disadvantaged.

**Principle 3:**
Collaborative health promotion and disease and injury prevention by all sectors.

**Principle 4:**
Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay.

**Principle 5:**
Acknowledging the special relationship between tangata whenua and the Crown under the Treaty of Waitangi.

**Principle 6:**
A high-performing system in which people have confidence.

**Principle 7:**
Active involvement of consumers and communities at all levels.

**Principle 1** reflects the clear focus of the sector on good health and wellbeing. This applies at both the individual level (for example, with treatment services) and at the community level (for example, with health promotion services). This focus continues throughout people’s lives. The Government recognises that good health and wellbeing rely on a range of factors, many of which are outside the health sector itself. The sector must, therefore, seek to move towards more intersectoral ways of working to ensure that these linkages can be made, both centrally and locally.

**Principle 2** identifies the opportunity for health improvement within the population. Health improvements are not shared equally by all sectors of society. We need to increase our efforts to address the low health status of groups with low socioeconomic status, Māori and Pacific peoples, and people with serious mental illness.

**Principle 3** reflects the Government’s desire to have a health system that promotes good health and ‘wellness’ as well as treating illness. Many of the illnesses affecting the population of New Zealand are potentially preventable and we need to do better at addressing all the determinants of health.

**Principle 4** reflects the fact that fairness is a fundamental value for most New Zealanders, and the health sector must ensure that New Zealanders with similar health conditions are able to achieve similar outcomes. There is clearly a gap at present where people with high needs are sometimes not receiving the care they require.
Principle 5 recognises that the Treaty of Waitangi is New Zealand’s founding document and is a basis of constitutional government in this country. The Government recognises Māori as both a social group and as tangata whenua, and is committed to fulfilling its obligations as a Treaty partner to support self-determination for whānau, hapū and iwi. It has also acknowledged that this special constitutional relationship is ongoing and is based on the underlying premise that Māori should continue to live in Aotearoa as Māori. The nature of this relationship has been confirmed through interpretations of the Treaty of Waitangi, which stem from decisions of the Waitangi Tribunal, the Courts of Appeal and the Privy Council.

Central to the Treaty relationship and implementation of Treaty principles is a common understanding that Māori and the Crown (including Crown entities such as District Health Boards) will have a shared role in implementing health strategies for Māori, and relate to each other in good faith with mutual respect, co-operation and trust.

Māori should be able to define and provide for their own priorities for health and be encouraged to develop the capacity for delivery of services to their communities. This needs to be balanced by the duty of the Crown to govern on behalf of the total population.

To date, the relationship between Māori and the Crown in the health and disability sector has been based on three key principles:

- participation at all levels
- partnership in service delivery
- culturally appropriate practices.

These principles imply that not only is it important to improve Māori health status, but also that other goals based on concepts of equity, partnership, and economic and cultural security must be achieved.

Principle 6 reflects the fact that the health sector must continue to perform to the highest standards and reflect the needs of the people of New Zealand within available resources. The quality of health services needs to be continually monitored and improved. Services must be co-ordinated and providers must collaborate to ensure that institutional boundaries do not compromise quality of care.

Principle 7 identifies the need to have consumers and communities involved in decisions that affect them. This process should also seek to ensure that services fully reflect the needs of individuals and communities at all levels of the health sector.
Chapter 4: Goals and Objectives

Goals, objectives and targets

The framework for achieving the Health Strategy is based on a set of goals, which are broad strategic statements. The focus for achieving these goals is sharpened as we move through objectives, to targets, and ultimately to performance measures.

Why have goals and objectives?

Goals and objectives translate the broad intentions of the Government into the focused actions (‘strategies’) required to make a difference to improving health. Decisions on setting priorities and the effective use of resources are made all the time throughout the health sector. Developing a nationwide set of goals and objectives will assist the whole sector to direct their actions in a more co-ordinated and effective way.

History of goal-setting in New Zealand

An initial set of 10 health goals was issued by the Department of Health in 1989. These served as the basis for the Ministry of Health’s goals, objectives, and targets, initially formulated under the auspices of the Public Health Commission, following consultation and the 1993 and 1994 reports on the state of the health of New Zealanders. The monitoring of these targets was first reported in the 1994 edition of Progress on Health Outcome Targets and subsequently in annual publications.

The proposed goals and objectives in this chapter extend and refine this work. They take account of more recent data and analyses of health issues (Ministry of Health 1999b) and the resulting specific policies and programmes that have been developed in the interim. They also extend the scope beyond public health to engage the whole health sector.

From the 50 proposed objectives, 12 ‘priority’ objectives have been chosen. These objectives provide immediate focus for making a difference.

How will they work?

The Government will establish goals and objectives through a two-way process which draws on the input and endorsement of the health sector. The sector will then lead the process to develop strategies to achieve the goals, targets and performance indicators. Where strategies already exist, they will be strengthened. Over time, the framework of goals and objectives can be expected to influence all health sector processes, including needs assessment, priority setting, resource allocation, outcomes monitoring, service evaluation and planning, workforce and provider development, information systems and intersectoral co-ordination.

Terminology

Goal – a high-level strategic statement.
Objective – a more directed aim, which contributes to achieving a goal.
Target – a specific and measurable aim which contributes to achieving an objective.
Strategy – a course of action to achieve the target(s).
Performance indicator – a measure to assess performance with respect to the implementation of specific strategies.
How are they chosen?

The Ministry of Health has developed a draft set of goals and objectives, with advice from an Expert Advisory Group. The final selection has been made by the Ministry of Health. Goals and objectives were selected according to the degree to which they had the potential:

- to improve the health status of the population
- to reduce health inequality
- to engage the health sector and enhance the focus on outcomes (especially with regard to primary health care and preventive services)
- to engage other sectors, reflecting the scope for intersectoral action in addressing the determinants of health (including housing and education)
- for greater inclusiveness – to encompass all groups within society (such as age groups)
- for continuity with previous efforts at goal-setting, and with other strategic frameworks already in use
- for gaining widespread public support
- to provide focus, direction and a sense of leadership for the District Health Boards – including an ability to link a goal to specific objectives and so on through to measurable targets
- to effect the intent of the Treaty of Waitangi.

Structuring goals and objectives

The goals and objectives have been structured to reflect the wide range of factors that impact on health. The process began by addressing society-wide issues, such as employment and income status. The next step was to assess the immediate environment in which people live and the potential for effecting health improvement within this environment. Consideration was then directed toward lifestyle behaviours and specific diseases, and the impact on the health sector such objectives would have. The outcome was a set of nine goals and 50 objectives. The process was informed by the recent reviews of health status (Ministry of Health 1999b, National Health Committee 1998) as well as the professional judgement of the Expert Advisory Group and the Ministry of Health.

From the set of objectives, 12 have been highlighted for immediate attention. These will be adopted nationwide and will be reflected within accountability agreements between District Health Boards and the Minister of Health. It is likely that these objectives will have different time scales for attainment. District Health Boards will be expected to determine which other objectives and/or targets are most appropriate to their local population needs. They will do this in consultation with local communities.
Goals and objectives to address social inequalities in health

It is evident that factors such as housing and income have a major impact on the health of individuals. Other agencies are responsible for specific policies and programmes in these areas, but the health sector has an important role in contributing to intersectoral approaches to address such issues at both a national and a local level. This includes assessing relevant public policies for their impact on health and health inequalities. It is important for the Ministry of Health and District Health Boards to ensure health services are developed that reflect this wider focus.

A sector-wide approach to improving population health

Population health improvement is intimately linked with the whole health sector. Just as health professionals played a key role in leading societal change over tobacco consumption, there is the potential for the health sector to play a leadership role in improving other aspects of population health. This may range from improving uptake of screening programmes among higher-risk populations, to promotion of healthy nutrition and physical activity, through to implementing evidence-based guidelines for treatments to improve individual outcomes. A reorientation of emphasis right throughout the sector towards achieving outcomes is required to achieve goals such as improved population health and a reduction of health inequalities.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
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</table>
| 1. A healthy social environment | 1. To assess all public policies for their impact on health and health inequalities.  
2. To support policies promoting universal access to high-quality education and training.  
3. To support policies promoting labour force participation.  
4. To support policies that reduce income inequalities and ensure an adequate income for all. |
| 2. A healthy physical environment | 5. To support policies and develop strategies and services that ensure affordable, secure and safe housing for all.  
6. To support policies that improve access to public transport.  
7. To support policies that ensure access to an adequate supply of safe and nutritious food.  
8. To support policies and develop strategies and services that ensure all people have access to safe water supplies and effective sanitation services. |
<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
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<tbody>
<tr>
<td>3. Healthy communities, families and individuals</td>
<td>9. To support and promote community development.</td>
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<td>10. To develop and implement healthy workplace programmes.</td>
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<td>11. To further develop health-promoting schools.</td>
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<td>12. To ensure adequate support for parents and young families.</td>
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<td></td>
<td>13. To ensure adequate support for caregivers in families with dependent members.</td>
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<td></td>
<td>14. To support policies and programmes that promote positive ageing.</td>
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<td>4. Healthy lifestyles</td>
<td>15. To reduce smoking.</td>
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<td></td>
<td>16. To improve nutrition and reduce obesity.</td>
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<td></td>
<td>17. To increase the level of physical activity.</td>
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<td></td>
<td>18. To improve sexual and reproductive health.</td>
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<td></td>
<td>19. To minimise harm caused by alcohol, illicit and other drug use to both individuals and the community.</td>
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<td></td>
<td>21. To reduce the incidence and impact of depression.</td>
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<td></td>
<td>22. To reduce the incidence and impact of dementia.</td>
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<tr>
<td></td>
<td>23. To improve the health status of people with severe mental illness.</td>
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<td></td>
<td>24. To reduce the rate of suicides and suicide attempts.</td>
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<td></td>
<td>25. To reduce stigma and discrimination associated with mental illness.</td>
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<td></td>
<td>27. To reduce the incidence and impact of cardiovascular diseases.</td>
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<td></td>
<td>28. To reduce the incidence and impact of diabetes.</td>
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<td></td>
<td>29. To reduce the incidence and impact of asthma and other lung diseases.</td>
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<td></td>
<td>30. To reduce the incidence and impact of musculoskeletal disorders including arthritis.</td>
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<tr>
<td></td>
<td>31. To reduce the incidence and impact of neurological disorders.</td>
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<tr>
<td></td>
<td>32. To improve oral health.</td>
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<td></td>
<td>33. To reduce the incidence and impact of infectious diseases.</td>
</tr>
<tr>
<td>Goal</td>
<td>Objective</td>
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</tbody>
</table>
| **7. Fewer injuries** | 34. To reduce the incidence and impact of road traffic injuries.  
35. To reduce the incidence and impact of falls in older people.  
36. To reduce the incidence and impact of injuries (other than traffic) in children and youth.  
37. To reduce the incidence and impact of violence in interpersonal relationships, families, schools and communities. |
| **8. More accessible and appropriate health care services** | 38. To ensure access to appropriate secondary care services.  
39. To ensure access to appropriate primary care, maternity and public health services.  
40. To ensure access to appropriate child health care and immunisation services.  
41. To ensure access to appropriate mental health services.  
42. To ensure services are responsive to patient expectations.  
43. To ensure services are delivered according to people’s needs.  
44. To ensure accessible and appropriate services for Māori.  
45. To ensure accessible and appropriate services for Pacific peoples. |
Reducing health disparities for Māori

Māori health objectives will be a part of all of the goals and objectives listed above. In addition a specific goal is proposed for Māori health development as detailed below.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
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<tbody>
<tr>
<td>9. Māori development in health</td>
<td>46. To build the capacity for Māori participation in the health sector at all levels.</td>
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<td>47. To enable Māori communities to identify and provide for their own health needs.</td>
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<td>48. To recognise the partnership arrangement between tangata whenua and the Crown in health services, both mainstream and those provided by Māori.</td>
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<td>49. To collect high-quality Māori health information to better inform Māori policy and research, and focus on health outcomes.</td>
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<td></td>
<td>50. To foster and support Māori health workforce development.</td>
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</tbody>
</table>

Goals can be framed according to issues or population groups. The goals presented here are mainly related to an issues approach. The following diagram demonstrates how goals will be applied to population groups.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Māori</th>
<th>Pacific peoples</th>
<th>Children</th>
<th>Young people</th>
<th>Adults</th>
<th>Older people</th>
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<tbody>
<tr>
<td>A healthy social environment</td>
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<td>A healthy physical environment</td>
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<td>Healthy communities, families and individuals</td>
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<tr>
<td>Healthy lifestyles</td>
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<tr>
<td>Better mental health</td>
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<tr>
<td>Better physical health</td>
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<td></td>
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<tr>
<td>Fewer injuries</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>More accessible and appropriate health care services</td>
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<tr>
<td>Māori development in health</td>
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</tbody>
</table>
Priority areas in population health

Twelve objectives have been chosen for immediate action. The Government intends focusing Ministry of Health and District Health Board attention on these objectives (in random order – not ranked):

- To address the health disparities between Māori, Pacific peoples and other New Zealanders
- To reduce smoking
- To improve nutrition and reduce obesity
- To increase the level of physical activity
- To reduce the rate of suicides and suicide attempts
- To minimise harm caused by alcohol, illicit and other drug use to both individuals and the community
- To reduce the incidence and impact of cancer
- To reduce the incidence and impact of cardiovascular disease
- To reduce the incidence and impact of diabetes
- To improve oral health
- To reduce violence in interpersonal relationships, families, schools and communities
- To ensure access to appropriate child health care and immunisation services.

The rationale for selecting these particular objectives is as follows:

To address the health disparities between Māori, Pacific Island and other New Zealanders

Initiatives to address disparities are discussed within Chapter 5.

To reduce smoking

Tobacco smoking is the major cause of preventable death in New Zealand. Each year about 4700 of all deaths are attributable to smoking (Ministry of Health 1999b). Parental tobacco smoke and environmental tobacco smoke are related to a number of conditions (for example, sudden infant death syndrome, the childhood risk of croup, pneumonia and asthma). There is good evidence that morbidity and mortality can be substantially reduced using prevention approaches.

To improve nutrition and reduce obesity

Recent data show that 15 percent of males and 19 percent of females are obese, and 40 percent of males and 30 percent of females are overweight (but not obese) (Ministry of Health 1999a). These prevalences are likely to increase. Obesity is one of the most important avoidable risk factors for a number of life-threatening diseases and for serious morbidity. About 11 percent of Māori and 6–7 percent of non-Māori deaths in the 45–64 years age groups are attributable to obesity (Ministry of Health 1999b). Obesity also has an important relationship with diabetes.
To increase the level of physical activity

Lack of regular physical activity is a modifiable risk factor for major heart conditions such as heart disease, stroke, hypertension and premature death. At least one-third of New Zealand adults are insufficiently physically active, and lack of physical activity is estimated to account for over 2000 deaths per year (Ministry of Health 1999b). There is good evidence that 30 minutes of moderate exercise each day reduces risk.

To reduce the rate of suicides and suicide attempts

New Zealand’s youth suicide rate is one of the highest in the OECD countries. There are differences in the rates of completed and attempted suicides, with females having higher rates of attempted suicide but lower rates of completed suicides than males.

To minimise harm caused by alcohol, illicit and other drug use to both individuals and the community

Over 80 percent of adult New Zealanders consume alcohol. At some time in their life, nearly one in five New Zealanders will suffer an alcohol use disorder. Alcohol abuse is a risk factor for some types of cancer, stroke, and heart disease. Alcohol abuse also significantly contributes to death and injury on the roads, to drowning, to suicide, to assaults and to domestic violence. The abuse of illicit drugs also causes harm to some New Zealanders. Of particular concern is the risk to public health from the transmission of blood-borne viruses through the sharing of needles and syringes, and cognitive impairment. People who experience both drug and mental health problems have particularly poor health outcomes.

To reduce the incidence and impact of cancer

Cancer is the second leading cause of death (27%) and a major cause of hospitalisation (7%) in New Zealand. There are about 17,000 new registrations of cancer each year, with the highest rates in the middle and older age groups.

To reduce the incidence and impact of cardiovascular disease

Cardiovascular disease is the leading cause of death (accounting for about 40 percent of deaths) and morbidity in New Zealand (24 percent of the total fatal and non-fatal burden) (Ministry of Health 1999b).

To reduce the incidence and impact of diabetes

Diabetes is estimated to cause about 1200 deaths per year (Ministry of Health 1999b), and diabetic complications (such as heart disease, blindness, kidney failure) are major contributors to the burden of disability experienced by people from middle age, especially in the Māori and Pacific communities. Projections are for a significant increase in the prevalence of diabetes in the next 10 years.

To improve oral health

Diseases of the teeth and gums are among the most common of all health problems and are experienced by all New Zealanders at some stage of their life. Dental problems cause much pain and discomfort and can often contribute to a loss of self-esteem. It is now apparent that there are significant inequalities in oral health status between different population groups. In
particular, Māori and Pacific children and adolescents have worse oral health than non-Māori and non-Pacific children.

**To reduce violence in interpersonal relationships, families, schools and communities**

In many countries violence is recognised as a key public health issue. Child abuse, sexual violence, family violence, school bullying and elder abuse are all preventable forms of harm and social disruption.

**To ensure access to appropriate child health care and immunisation services**

Many indicators of child health show that New Zealand has a low international ranking of child health (for example, high rates of unintentional injury). Vaccine-preventable diseases are an important cause of morbidity and mortality for all communities. New Zealand has a relatively low immunisation rate and there is an ongoing cycle of epidemics of vaccine-preventable diseases such as whooping cough (pertussis) and measles.

Examples of the current targets for each of these areas are included in Appendix 3. There needs to be further development of these targets to bring a closer focus on addressing inequalities. For example, we currently have few targets addressing Pacific health issues.
Chapter 5: Service Priorities

The previous chapter looked at population health goals and drew up 12 objectives for immediate action. This chapter focuses on six additional service-delivery priority areas that the Government wishes the health sector to concentrate on in the short to medium term.

Service priority areas:
- public health
- primary health care
- reducing waiting times for public hospital elective services
- improving the responsiveness of mental health services
- Māori advancement in health
- improving Pacific people’s health.

Public health

Public health professionals and service providers take a lead role in improving population health outcomes, and in reducing disparities in health status through disease prevention, health promotion and health protection programmes. For example, they have a role in ensuring the safety of the air we breathe, the water we drink, and the food we eat. Public health programmes focus on enabling people to make individual and collective choices which improve their health. These programmes address issues such as mental health promotion, reduction in harm from drug use (including alcohol and tobacco), and immunisation promotion. Public health experts also play a role in promoting healthy public policy: through submissions to central and local government agencies on key issues relating to population health, and through assessing public policies for their impact on health and health inequalities.

Improving the impact of public health services in the future will require:
- the further development of Māori health providers and organisations
- the development of Pacific peoples’ public health services
- increased delivery of health promotion initiatives in community and primary care settings
- improved access to public health protection services in rural areas, with a focus on clean water, sewerage and housing.

Primary health care

Primary health care will be critical to improving health and closing the gaps in health status between Māori and Pacific peoples and other New Zealanders. Primary health care is delivered close to communities, and is a key to improving and maintaining health through programmes that aim to promote health, prevent disease and provide treatment for illnesses early to prevent complications developing. Rural primary health care is an important component of services in rural areas, and poses particular challenges of support for isolated practitioners.
An increase in the number and variety of Māori primary health care providers and the emergence of Māori development organisations are essential components of an effective primary care sector. Priority will be given to ensuring existing successful Māori providers are not only consolidated but grown. This will ensure that options and choices will become a reality for Māori, and that issues such as equitable access begin to be addressed.

Consultation on the discussion document *The Future Shape of Primary Health Care* took place recently. The results of the consultation are not yet known: the Government will release the definitive strategy after careful consideration of the outcome of the consultation process.

Ensuring comprehensive primary care coverage and quality primary care services are priorities for District Health Boards as they work with local primary care providers.

**Reducing waiting times for public hospital elective services**

Waiting times for admission to hospital for elective (non-emergency) surgical and non-surgical treatments continue to be unacceptably long in a number of areas. District Health Boards will need to place priority on reducing elective waiting times and giving patients certainty about timeframes.

The Government’s four key objectives for reduced waiting times and more equitable access to services are aimed at ensuring:

- national equity of access to elective services so that patients have similar access regardless of where they live
- a maximum waiting time of six months for the first specialist assessment
- reasonable maximum waiting times for elective surgery will be set
- delivery of a level of publicly funded service which is sufficient to ensure access to elective surgery before patients reach a state of unreasonable distress, ill health, and/or incapacity.

The seven strategies for achieving these objectives are:

- nationally consistent clinical assessment
- increasing the supply of elective services
- giving patients certainty
- improving the capacity of public hospitals
- better liaison between primary and secondary sectors
- actively managing sector performance
- building public confidence.
Current criteria include:

- People have direct and immediate access to emergency medical services and move through these services to the most appropriate level for treatment.
- For non-emergency services, waiting times are as follows:
  - 90 percent of people assessed by a specialist within two months of referral
  - 100 percent of people assessed by a specialist within six months of referral
  - 100 percent of people assessed by a specialist as meeting the criteria for publicly funded treatment receive treatment within six months of the assessment.

Sector performance in meeting these criteria will be monitored and the criteria will be continually assessed in the light of that information.

**Improving the responsiveness of mental health services**

The level and quality of specialist mental health services have improved over recent years. Significant gains are still required to ensure that services are able to meet the full range of needs of people who experience mental and psychological distress. The Government is committed to continually improving mental health services through implementing the Mental Health Commission’s Blueprint, which draws on the objectives of *Looking Forward* (Ministry of Health 1994) and *Moving Forward* (Ministry of Health 1997). This will result in comprehensive services that lead to:

- People with mental illness being treated fairly, with respect and with dignity
- People with mental illness having the opportunity to participate fully in their communities free from negative discrimination
- More services that are easier to access and that are able to respond to a diverse range of needs more quickly
- A better quality of services that are able to identify and respond to needs in a way that promotes recovery.

Improvements are needed in all mental health services, but there must be emphasis on improving mental health services for children and young people, older people, Māori and Pacific peoples. At a local level there will be other service priorities (for example, services for people with alcohol and drug problems, including those in need of methadone services; services for people with multiple, complex and high support needs; and services for older people).

Collaboration between providers of mental health services is imperative. Hospital-based and community-based services must collaborate with each other as well as with non-governmental providers and primary health care services. All are integral to improved co-ordination of mental health services. Equally importantly, there need to be appropriate referrals, assessments and comprehensive strategies with other sectors (such as housing) to ensure that people’s full range of needs are met.
Current criteria include:
Crisis services to deal with a critical or urgent mental health need will be available to people (regardless of whether or not they come under the Mental Health (CAT) Act 1992) as follows:

- telephone or other remote assistance will be available at all times with minimal delay
- where telephone assistance is insufficient to meet a person’s needs, direct contact with a clinician will be provided as soon as possible
- other services will be arranged where required, including acute inpatient admission and crisis respite.

The National Mental Health Plan *Moving Forward* (Ministry of Health 1997) and *New Futures* (Ministry of Health 1998), the strategic framework for specialist mental health for children and young people, contain the following national targets:

- 3 percent of adults able to access specialist mental health services in any one month
- 1.0 percent of young people aged 0–9 years able to access specialist mental health services in any one month
- 3.9 percent of young people aged 10–14 years able to access specialist mental health services in any one month
- 5.5 percent of young people aged 15–19 years able to access specialist mental health services in any one month.

These targets are not yet achieved.

- For crisis situations, 90 percent of people should be assessed by a mental health professional within four hours.
- For non-crisis situations, the ability of services to respond is limited, and this is likely to continue for some time. Services need to inform people of the treatment options that are available to them if they cannot see a specialist. This may include, for example, primary care support.

**Māori advancement in health**

Improvements in Māori health status are critical, given that Māori on average have the poorest health status of any group in New Zealand. The Government has acknowledged the importance of prioritising Māori health gain and development by identifying that health inequalities which impact negatively on Māori must be reduced and eventually eliminated.

Working towards closing the gaps will involve government departments and agencies working co-operatively across sectors, community engagement, and community development.

The progress of achievements since the mid-1980s must continue. Some examples include:

- growth and upskilling of Māori providers
- expansion of the Māori workforce at all levels of the health sector
- enhancement of mainstream providers’ ability to meet Māori needs and expectations
- increased Māori participation at all levels of the public health sector
- reinforcing the established ‘matrix of relationships’ throughout the health sector.

A Māori health strategy will be available by December 2000, and will provide the detail unable to be captured within the New Zealand Health Strategy.
Closing the gaps for Māori in the short to medium term includes but is not limited to:

- attention on addressing He Pūtahitanga Hōu objectives relating to rangatahi health, disability support services and alcohol and drug services
- improving the quality and effectiveness of health promotion and education programmes targeted at Māori
- forming effective partnerships at all levels under the Treaty of Waitangi
- enhancement of mainstream providers
- increased Māori participation at all levels of the public health sector
- an established matrix of relationships vertically and horizontally throughout the health sector
- increased participation and involvement of Māori health providers across the health sector
- improved mental health services to Māori, which take into account Māori healing
- an increased number of Māori in the health workforce, particularly in mental health
- promotion of smoking cessation programmes
- increasing resources to Māori health providers delivering sexual and reproductive health services.

Existing Māori health gain priority areas will continue to receive attention. The eight priority areas are:

- immunisation
- hearing
- smoking cessation
- diabetes
- asthma
- mental health
- oral health
- injury prevention.

**Improving Pacific people’s health**

The Government is developing a work programme called Closing the Gaps for Māori and Pacific peoples. The overall aims of this programme are described in Chapter 2. The specific aims for Pacific peoples are to:

- strengthen primary health initiatives for Pacific peoples
- improve the health of Pacific children
- improve mental health services for Pacific peoples
- enhance screening programmes to improve the health of Pacific peoples
- increase the number of Pacific people in the health workforce.
A Pacific Health Strategy will be developed. This will include the following components:

- public health programmes, utilising health promotion and health protection strategies, to address key issues such as childhood infectious diseases, diabetes, heart disease and obesity, women’s health, family planning, and injury prevention

- primary care programmes to improve access to quality services for Pacific people, especially in areas where they work and live. These will include Pacific provider development support and will focus on improving prevention programmes (for example, Well Child services) and to ensure that they are well co-ordinated with culturally competent community-based services with leadership by Pacific peoples

- improved specialist services based in the community for key Pacific health issues such as diabetes, ophthalmology, asthma, paediatrics, mental health, and maternity services; these will be well co-ordinated with other types of services for Pacific peoples

- training and support to increase the Pacific health workforce, in liaison with the education sector

- research

- collection of quality Pacific health information

- more culturally competent services delivered by mainstream providers.
Chapter 6: Implementation: Quality Services

This chapter focuses on the need to ensure that the performance of health services, and the health system as a whole, results in better health outcomes and a reduction in health disparities. In particular, health services should meet people’s needs, be clinically sound, culturally competent and well co-ordinated. They should also be efficiently delivered. Budgets are capped and distributed through the population-based funding formula and the health sector will need to ensure that limited resources are used in the best way possible to achieve these aims.

The Government seeks a high-performing system in which people have confidence. The Government is committed to working with the sector to remove barriers to performance. The continued hard work, dedication and commitment of those working in the sector are crucial to building a better health system.

Individual rights

Individuals have fundamental rights within a quality health care system. These include rights under the Privacy Act 1993 and those recognised in legislation through the Health and Disability Commissioner Act 1994.

The latter Act covers the:
• right to be treated with respect
• right to freedom from discrimination, coercion, harassment and sexual exploitation
• right to dignity and independence
• right to services of an appropriate standard
• right to effective communication
• right to be fully informed
• right to make an informed choice and give informed consent
• right to support
• rights in respect of teaching or research
• right to complain.

Each part of the system must perform highly

The Ministry of Health will lead policy work to support the New Zealand Health Strategy. Its role and the role of District Health Boards are described in Appendix 2.

All service providers must ensure that their services:
• are responsive to need
• are culturally competent
• are clinically effective
• are safe
• utilise evidence-based practice
use resources effectively
reflect the Government’s fundamental principles.

The Government does not accept that services should be adequate – they must be better than that. Each part of the sector must ensure that it has internal and external quality systems and processes that encourage continuous quality improvement, and allow external and public scrutiny of quality standards.

The Government expects the sector to continue to develop a framework for reporting on clinical quality reporting that facilitates benchmarking across the sector. This will include benchmarking at a District Health Board level.

**Improved co-ordination**

In order for health services to address the needs of local communities and individuals, more co-ordinated and complementary ways of working across the sector need to be established. Competition between providers or professional groups has inhibited the development of services oriented to the needs of individuals and communities.

However, in many parts of the country initiatives have been taken to overcome these barriers. These include initiatives designed to meet the needs of specific population groups (such as Māori, Pacific peoples, youth, children and their families, or older people), or specific groups of patients (such as people with diabetes or those requiring elective services). Most of these initiatives have been developed by local communities, health organisations or providers themselves.

It is important for District Health Boards to look at how they can foster such initiatives, which are oriented towards improving health outcomes for individuals and communities and focus on eliminating health inequalities. District Health Boards will need to consider:

- relationship development
- specific funding earmarked for the support of local initiatives to reduce health inequalities and improve health outcomes
- learning from successful initiatives in other District Health Board areas (for example, through dissemination of information, site visits and secondments)
- working with other government agencies locally
- assessing local government policies for their impact on health and health inequalities.

The Government expects District Health Boards to ensure that service providers in their districts work with each other to continue to further integrated care across public health, primary care, community-based care and secondary/tertiary services.

District Health Boards will need to work with each other and are required to plan regionally to ensure access for their populations to regional and national services. This is particularly important for mental health services.

Youth health and the health of older people are areas that require greater co-ordination. The Ministry of Health will therefore develop a Youth Health Strategy and a Strategy for Older People to address these issues.
Overcoming the problems arising from isolation in rural areas

Rural areas require extra support to ensure adequate quality services are available for communities and patients. Providers also have special needs for support.

Extra support is available, or will shortly be made available, for rural health services. This includes funding of programmes for:

- continuing education for nurses and doctors
- directors of rural health in the South Island and North Island
- a bonus for providers in rural areas
- locum support
- increased support to enable the retention of services in communities facing special difficulties.

Consultation on the discussion document *The Future Shape of Primary Health Care* will provide further information on the primary care needs of rural areas. It is important for rural people to have certainty of what they can expect, and it may be desirable to develop national specifications setting down expected levels of availability of services.

A high-performing health sector to improve outcomes for Māori

The relationship between Māori and the Crown will continue under the Treaty of Waitangi irrespective of health disparities.

The health sector must recognises the difference between reducing disparities for Māori as a population, and meeting the obligations that stem from the special partnership relationship between tangata whenua and the Crown. Both have implications for the health sector if there is to be an improvement in outcomes for tangata whenua.

An effective health sector will ensure that:

- Māori capacity within the sector is increased, developed and fully involved at all levels of the sector, so that it works to reduce the health disparities between Māori and non-Māori
- the partnership relationship between tangata whenua and the Crown is reflected throughout the health sector by the formation of partnerships at the governance levels. These partnerships will take various forms according to the circumstances.

The majority of resources and services for Māori are delivered by mainstream services so it is essential that these services are clinically and culturally effective for Māori.

An effective relationship between tangata whenua and the health sector requires:

- effective relationships between District Health Boards and Māori
- specific funding of services to achieve health gains for Māori
- growth and development of Māori providers
- overall growth and development of the Māori health workforce capacity and expertise
- co-ordinated and prioritised research for Māori health
- building on the gains and momentum achieved to date
• continuing to build Māori capacity throughout the health and disability sector, and ensuring Māori communities are able to identify and provide for their own health needs

• improved and timely access to a range of effective health services from both independent Māori providers and mainstream providers

• corresponding reductions in avoidable illness and decreased Māori health disparities

• greater health sector responsiveness to Māori needs and expectations

• whānau, hapū, iwi and Māori communities being empowered to achieve their own goals in the health sector.

Information management and technology

The ability to exchange high-quality information between partners in health care processes will be vital for a health system focused on achieving better health outcomes. Better access to timely and relevant clinical information can improve clinical decision-making and, therefore, health outcomes for individual patients. Privacy and confidentiality of personal information must be maintained at all times in compliance with the Privacy Act 1993 and the Health Information Privacy Code 1994.

Communities with access to better (non-personal) information about their health or health care services are able to play a greater role in maintaining their own health and accessing appropriate health services, and in contributing to decision-making on local health services. For example, ethnicity-related information will ensure that Māori communities and the Government are better informed.

This means a nationally coherent and consistent approach to a health information infrastructure, based on improving access to information and the consolidation of appropriate standards. At this point it is particularly important to ensure that District Health Boards develop consistent and compatible information systems.

A National Health Information Strategy is being developed to support implementation of the New Zealand Health Strategy.

Workforce issues

Health services in the future may require a different mix of workforce skills to those of the present. Issues include:

• mental health services have already undergone a change from institutional care to community-based care for many people, but more skilled personnel are required in community-based and primary health care settings

• Māori development and action on closing the gaps in health inequalities will require the continuation of work to date

• changing health needs as the population ages may create a need for more community nursing support, and training and support for carers and volunteers

• advances in technology may require different specialist skills, such as tele-medicine, and the provision of more community-based clinics run by a range of appropriately qualified health providers
• increased action to close the gaps in health inequalities will require increased numbers of trained Pacific health workers

• support and supervision of professionals in training, pre-registration and post-registration, as well as ongoing continuing education, especially in rural areas.

To meet these changing needs it is necessary to develop central leadership. The Government has therefore decided to establish a Health Workforce Advisory Committee (HWAC) this year in order to provide advice on workforce needs in the sector, and on how to meet these needs. It is proposed that the HWAC liaise with providers, professional bodies, non-governmental organisations, community groups, the education sector and other organisations (such as the Mental Health Workforce Society and the Community Support Services Industry Training Organisation) in order to monitor changing needs, and to match workforce needs with the provision of appropriate training and education.

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

Nationwide priority goals and objectives are identified in the New Zealand Health Strategy. District Health Boards will be expected to meet performance targets in relation to these.

It is, however, desirable to allow some local flexibility for action on key health issues. The health needs of communities served by District Health Boards will vary according to population mix. In the process of assessing needs and closing gaps in provision, District Health Boards will identify local health priorities for action, in consultation with their communities. Suitable performance measures to monitor and evaluate District Health Board performance on these issues will be identified in their Funding Agreements with the Minister of Health.

Initially, District Health Boards will be established with largely prescriptive Funding Agreements. This is to give stability and security to the public and providers within the health sector. Over time, as District Health Boards become well established and perform well, there will be increased opportunities for more local flexibility.

**Mechanisms for achieving a high-performing system**

District Health Boards will be funded according to the composition of their population. It will be the primary function of District Health Boards to ensure that they maximise the health gain and independence of their resident populations, subject to the resources made available to them.

A high-performing system will be ensured by four mechanisms:

• **Regulatory requirements**: for example, the Health and Disability Commissioner Act 1994; consumer safety legislation (currently before the house and designed to replace the Hospitals Act 1956, the Old People’s Regulations 1987, the Obstetric Regulations 1986 and sections of the Disabled Person’s Community Welfare Act 1975); occupational legislation which regulates health professionals; and the New Zealand Public Health and Disability Bill (to be introduced mid-year and which will establish District Health Boards).

• **Funding Agreements**: these will set obligations on District Health Boards to provide and arrange for the provision of certain services in return for money received from the Government. Similarly, District Health Boards will enter into Funding Agreements with
providers in their districts. These will stipulate the quality, access to and amount of services required. Monitoring is critical, and New Zealanders have a right to know how services compare across the country. Benchmarking of population outcomes between District Health Boards will provide the public with information on how we are doing.

- **Professionalism**: an important aspect of a high-performing system. Those working in the sector have key roles in ensuring the system works for those for whom it is designed. Clinicians and non-clinicians, support workers and managers, paid workers and volunteers are all essential to making a difference: it is people with integrity serving people in need who ultimately guarantee a high-performing system. Likewise, health organisations need to foster and support their workforce and volunteers.

- **A learning culture conducive to continual quality improvement**: research and evaluation are crucial to gathering evidence as to whether a treatment, practice or process works better than alternatives, and in what circumstances. Openness to evaluation and constant searching to find ways to do better are crucial to high-performing systems. There must be active promulgation of best practice.
Chapter 7: The Process for Further Strategy Development: Communities and Consultation

The development of the New Zealand Health Strategy is an ongoing process. After the consultation process for this document (Stage 1 of the Strategy) is completed, an amended (and final) version of the Strategy based on the feedback received will be adopted. However, this will not be the end of the process. In the future (Stage 2 of Strategy development) new components will be developed, including strategies for specific health issues or population groups. District Health Boards will be responsible for developing their own programmes of implementation for priority issues, and also for specific local needs. District Health Boards will be required to develop high-level strategic plans in consultation with their local communities. These strategic plans will take a 5–10-year perspective.

This means that further consultation will need to be carried out. Chapter 7 looks at ways that the Ministry of Health and District Health Boards could consult at national, regional or local levels.

Reasons for consultation

There are a number of reasons for ensuring that consumers, communities and providers are involved in strategy or programme development. These include:

- democratic participation: taking into account different perspectives
- partnership and collaboration: fostering shared ownership of solutions to problems, and therefore achieving more co-ordinated, committed action
- equity and fairness: fostering shared understanding, and arriving at equitable solutions
- accountability: from those who design and provide services to those who use them
- acceptability: fostering development of solutions that are acceptable
- ensuring the rights of consumers are upheld
- ensuring provider, community and consumer input is valued
- taking advantage of a range of expertise
- acknowledging and reflecting bicultural values
- adopting a holistic approach: considering issues in relation to communities, consumers and providers, and arriving at practical and effective decisions.

The consultation process

Elected membership of District Health Boards will help to ensure democratic participation in the decision-making process. However, this is not a substitute for community, consumer and provider involvement and participation in decision-making through other mechanisms. District Health Boards will establish a process whereby providers and users of services, and the community, will be able to have input into major decisions taken by the Boards.
Consultation should include those who provide or use services that could be changed as the result of a decision.

**Key points for consultation**

**What topics should be consulted on?**

The topics to be consulted on will be determined by legislation or Ministers, by the Ministry of Health or District Health Boards, or will arise from widespread concern about an issue. The choice of some issues will be clear-cut, for example, decisions that may substantially change the delivery of services or the development of new guidelines. There will also be a need to develop mechanisms whereby consumers and the general public can raise topics for consultation with the District Heath Boards and the Ministry of Health.

In many ways the mechanics of consultation – who to involve, the specific issues to be discussed, when people should be consulted and the resources to be allocated to consultation – are determined by the subject to be discussed. For instance, a consultation on delivering services to people with multiple sclerosis will probably focus on people with the condition and their providers and carers, and will be relatively focused. A consultation on an issue that has implications for large numbers of the community, such as prioritising services, will require a much wider consultation and therefore different methods.

**Who should be involved?**

As noted above, the choice of who to involve in the consultation will vary according to the issue. Those it may be appropriate to consult include:

- members of Māori communities
- Pacific peoples
- patients/users of health services (eg, youth, children, mental health services users)
- caregivers and family/whānau members
- health care providers
- members of other sectors (for example, local government, or central government agencies)
- representatives from community groups
- representatives from consumer groups
- other members of the general public
- non-governmental organisations providing health services
- other organisations with an interest in, or influence on, health
- experts in specific areas.

**Methods to use in consultation**

Consultation can take a number of forms. At one level there is ongoing consultation on a wide range of issues. District Health Boards can facilitate this through the appointment of community liaison officers and the establishment of community advisory committees.
There is also a need to develop specific consultation programmes for specific issues. Some factors to consider when designing such programmes include:

- the topic(s) of the consultation
- the key interest groups
- the depth of information or advice required
- the time available for consultation
- legislative requirements
- the resources (people and money) that are available for the consultation
- support for those involved in more time-demanding forms of consultation (for example, meeting travel and/or childcare costs for people attending focus groups distant from their home and/or work; fees for members of advisory groups)
- the provision of adequate information in a suitable format and in a timely fashion
- accessibility for people with disabilities.

Many methods have been used for consulting with consumers and providers in New Zealand and overseas. These include:

- written submissions (whether through the mail or the Internet), usually in response to a written document such as this one
- advisory groups (either standing or specific to the issue), which may include providers, community groups, consumers and informed individuals
- public (or community) meetings specific to an issue, or held regularly
- seminars and events to which community representatives are invited
- small group meetings (for example, focus groups or workshops)
- consumer surveys
- citizens’ juries
- surveys and other research methods
- hui
- fono or other appropriate methods for Pacific peoples
- communication from and through elected members of management boards
- freephone responses.

Guidelines for consultation in the health sector will be developed in due course.

The Ministry of Health is very keen to know your thoughts on consultation. The questions at the front of this discussion document may help you to provide important feedback that will help us design good consultation programmes at local, regional and national levels in the future.
Appendix 1: Membership of the Sector Reference Group and Expert Advisory Group

**Sector Reference Group**

Dr Karen Poutasi  
Ministry of Health (Chair)

Ms Lynette Stewart  
Te Tai Tokerau MAPO

Ms Jane Holden  
The Royal Foundation for the Blind

Ms Claire Austin  
Age Concern

Dr Colin Tukuitonga  
Māori and Pacific Health Unit, Auckland University

Dr Barbara Disley  
Mental Health Commission

Mrs Brenda Wilson  
New Zealand Nurses’ Organisation

Ms Karen Guililands  
College of Midwives

Dr John Broughton  
Department of Preventive and Social Medicine, Otago University

Dr Debbie Ryan  
South Seas Health Care, Otara

Dr Upali Manukulasuriya  
General Practitioner, Taumarunui

Ms Judith Stanway  
Crown Health Association

Ms Alison Paterson  
New Zealand Medical Association

Prof. Mason Durie  
School of Māori Studies, Massey University

Mr Stuart Bruce  
Health Advisor, Office of the Minister of Health

Dr David Bawden  
Tikipunga Medical Centre, Whangarei

Ms Cheryl Bawden  
Health Promotion Forum

Ms Pauline Hinds  
Mental Health Services, Lakeland Health

Ms Sandra Coney  
Women’s Health Action

Dr Jeff Brown  
Paediatrics Department, Palmerston North Hospital (ASMS)

Dr Don Matheson  
Health Funding Authority

**Expert Advisory Group**

Dr Don Matheson  
Health Funding Authority (Chair)

Assoc. Prof. Charlotte Paul  
Department of Preventive and Social Medicine, Otago University

Prof. Norman Sharpe  
School of Medicine, Auckland University

Dr Barry Gribben  
Department of General Practice and Primary Health Care, Auckland University

Dr Chris Cunningham  
School of Māori Studies, Massey University

Ms Ratana Walker  
Health Funding Authority

Dr Toni Ashton  
Department of Community Health, Auckland University
Appendix 2: Sector Changes

The health sector plays a key role in building healthy communities. The Government wants to create an environment that fosters sector collaboration and strong partnerships between all providers and communities. The focus will be on health outcomes and health processes – collaboration and co-ordination across the whole health and disability sector and across other government portfolios. In order to achieve this change, the Government has decided to:

- disestablish the Health Funding Authority (HFA)
- establish District Health Boards
- merge the current functions of the HFA with those of the Ministry of Health and District Health Boards.

This will bring decision-making closer to local communities. The District Health Boards will provide a local focus: the Ministry of Health, a nationwide approach.

The role of the Ministry of Health

The Ministry of Health will:

- manage all aspects of health policy advice to the Minister
- manage the relationships between the Ministry of Health, the Minister of Health and the District Health Boards
- fund and monitor the health and disability sector
- report regularly on health status throughout the country, including achievement of health goals and objectives
- enforce regulation and auditing.

In preparation for the reconfiguration of the sector, the Ministry is restructuring to form the following directorates:

- Sector Policy
- Māori Health
- Public Health (including population)
- Disability Issues
- Mental Health
- Personal and Family Services
- Sector Funding and Performance
- Corporate and Information.

These directorates will assist the Ministry in its leadership on key health and disability issues, and will provide the interface with the health sector that links the nationwide role with the district role.
The role of the District Health Boards

District Health Boards will work within allocated resources to:

- improve, promote and protect the health of a geographically defined population
- promote the health, wellbeing and independence of people with disabilities within that population
- reduce disparities in health and independence.

District Health Boards will have a majority elected membership with the first elections at the time of the local government elections in October/November 2001. The Government will appoint some members to complement those elected. From the enactment of legislation in 2000 until elections in 2001, the Government will appoint Transitional District Health Boards. In setting expectations for Transitional District Health Boards the Government is clearly stating its intention to make a difference – locally and nationwide.

District Health Boards may establish common service agencies between Boards to share administrative resources. District Health Boards need strong partnerships between all providers at a local level to engage local communities, including tangata whenua, to build effective healthy communities.

Responsibilities of the District Health Boards

District Health Boards will:

- assist the Crown in fulfilling its obligations as a Treaty partner: as Crown agencies, District Health Boards will be required to maintain relationships with tangata whenua and Māori in their districts that are characterised by reasonableness, open communication and consultation, mutual co-operation and utmost good faith
- support participation by Māori at all levels in their districts, actively support Māori provider development, and ensure that all services are delivered in ways that are effective for Māori
- balance national consistency with local responsiveness to particular local needs and preferences: Boards will involve local communities in discussions about allocation of resources and build understanding of decisions made on behalf of communities
- plan regionally with other District Health Boards to ensure that services are co-ordinated across district boundaries and that quality parameters are achieved
- be funded annually on a population-based formula that takes account of the size and characteristics of the populations they serve
- be required to keep administrative overheads to a minimum to allow for maximum investment of Vote Health into service delivery, whether public/population health initiatives, primary and community care, or hospital-related care
- be required to manage their spending within their annual financial allocation
- be open to monitoring and evaluation: good-quality information and a culture of openness and a willingness to share performance data are essential to allow comparison of District Health Boards’ achievements and for continuous improvement
- be encouraged to build on experience and constantly evaluate opportunities for more effective service delivery across the continuum of services locally and regionally
• function as learning organisations that are open to new ideas, and will support providers to build evidence of effectiveness

• be required to take a longer-term view: achieving and demonstrating health gain takes time, so District Health Boards need to take a long-term view of health outcomes and match that with longer-term funding arrangements.

**Accountability**

The presence of elected members will provide a strong incentive for District Health Boards to be mindful of the needs and priorities of local communities. Each District Health Board will be subject to a rigorous accountability regime through a Funding Agreement with the Minister of Health. This agreement will specify what District Health Boards can and cannot do, what they are expected to achieve, and how their performance will be measured.

These Funding Agreements with the Minister will be more comprehensive than the New Zealand Health Strategy but will incorporate all the priorities stipulated by the Government in the New Zealand Health Strategy. Funding Agreements will be negotiated annually between the District Health Boards and the Ministry of Health.

The District Health Boards’ annual plans will inform the Funding Agreement negotiations, and when the Funding Agreements are signed off the Minister of Health will monitor District Health Boards’ compliance with those Agreements.

**Managing change**

In managing change within the health sector the Government has signalled its confidence in all those working within it. Everyone has an important role to play in health gain. It is recognised that there are a large number of interests in the New Zealand health sector, but this diversity of commitment can be a strength if we can work together for patients, consumers and populations.

For those working in the sector, the Government has outlined some key change principles to guide the development process.

<table>
<thead>
<tr>
<th>Change principles for guiding health sector development:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• a focus on results – health gain for the population</td>
</tr>
<tr>
<td>• building forward – building on good initiatives and developments in the health sector</td>
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<tr>
<td>• reducing uncertainty as soon as possible – in particular, retaining people and skills within the sector</td>
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<tr>
<td>• establishing clear and effective lines of responsibility and accountability</td>
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<tr>
<td>• consensus building – working towards widespread sector support for change</td>
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<tr>
<td>• leadership – providing a clear view of where the sector is heading</td>
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<tr>
<td>• identification and management of risks.</td>
</tr>
</tbody>
</table>
New Zealand Health Strategy

Populations, Families, Individuals

22 District Health Boards, each with:
- Health Improvement Advisory Committee
- Hospital Governance Committee

Ministry of Health

Other Agencies, eg, National Health Committee, Mental Health Commission

Other Government agencies, eg, ACC

Finance and service monitoring information
Service specifications
Funding of certain national services

Minister of Health

Accountability
Appendix 3: Examples of Current Targets

This appendix lists existing targets against the proposed 12 priority population objectives described in Chapter 4.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Current Target</th>
<th>Current Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>To address the health disparities between Māori, Pacific peoples and other New Zealanders</td>
<td>Māori adult cigarette smoking</td>
<td>Proportion of Māori adults aged 15+ and cigarette smoking</td>
</tr>
<tr>
<td></td>
<td>Māori women smoking in pregnancy</td>
<td>Proportion of women smoking during pregnancy</td>
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<td></td>
<td>Hearing loss – Māori children</td>
<td>Audiometry repeat screen failure rate at school entry</td>
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<tr>
<td></td>
<td>Hearing loss – Pacific children</td>
<td>Audiometry repeat screen failure rate at school entry</td>
</tr>
<tr>
<td></td>
<td>Completed early childhood immunisation – Māori children</td>
<td>Proportion of Māori children with completed early childhood immunisation by age 2 years</td>
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<td></td>
<td>Burns – Māori children</td>
<td>Hospitalisations for burns from hot liquids – Māori children</td>
</tr>
<tr>
<td></td>
<td>Diabetes – Māori</td>
<td>Age-standardised mortality rate</td>
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<tr>
<td></td>
<td>Cervical cancer deaths – Māori women</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>Cervical cancer incidence – Māori women</td>
<td>Age-standardised incidence rate</td>
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<tr>
<td></td>
<td>IHD – Māori males</td>
<td>Age-standardised mortality rate</td>
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<tr>
<td></td>
<td>IHD – Māori females</td>
<td>Age-standardised mortality rate</td>
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<td></td>
<td>Stroke – Māori males aged 55+</td>
<td>Age-standardised mortality rate</td>
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<tr>
<td></td>
<td>Stroke – Māori females aged 55+</td>
<td>Age-standardised mortality rate</td>
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<tr>
<td></td>
<td>Missing or filled teeth in Māori Form 2 children</td>
<td>Average number per child</td>
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<td></td>
<td>Ectopic pregnancy in Māori women aged 15–44 years</td>
<td>Age-standardised rate</td>
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<tr>
<td></td>
<td>Acute rheumatic fever under 30 years – Māori</td>
<td>Hospital discharge rate</td>
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<tr>
<td></td>
<td>Hearing loss – Pacific children</td>
<td>Audiometry repeat screen failure rate at school entry</td>
</tr>
<tr>
<td></td>
<td>Acute rheumatic fever under 30 years – Pacific people</td>
<td>Hospital discharge rate</td>
</tr>
<tr>
<td>Objective</td>
<td>Current Target</td>
<td>Current Indicator</td>
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<tr>
<td>---------------------------------------</td>
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<tr>
<td>To reduce smoking</td>
<td>Tobacco products consumed</td>
<td>Consumption of tobacco per adult aged 15+</td>
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<td></td>
<td>Adult cigarette smoking</td>
<td>Proportion of adults aged 15+ cigarette smoking</td>
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<tr>
<td></td>
<td>Youth cigarette smoking</td>
<td>Proportion of adults aged 15–24 cigarette smoking</td>
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<tr>
<td></td>
<td>Māori adult cigarette smoking</td>
<td>Proportion of Māori adults aged 15+ cigarette smoking</td>
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<tr>
<td></td>
<td>Workers exposed to environmental tobacco smoke (ETS)</td>
<td>Proportion of indoor workers exposed to ETS during actual work hours</td>
</tr>
<tr>
<td></td>
<td>Workers exposed to ETS – tea and lunch breaks</td>
<td>Proportion of indoor workers exposed to ETS during tea and lunch breaks</td>
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<tr>
<td></td>
<td>Women smoking in pregnancy</td>
<td>Proportion of women smoking during pregnancy</td>
</tr>
<tr>
<td></td>
<td>Māori women smoking in pregnancy</td>
<td>Proportion of Māori women smoking during pregnancy</td>
</tr>
<tr>
<td>To improve nutrition and reduce obesity</td>
<td>Consumption of breads and cereals</td>
<td>Proportion of population consuming six or more standard servings per day</td>
</tr>
<tr>
<td></td>
<td>Consumption of fruit and vegetables</td>
<td>Proportion of population consuming five or more standard servings per day</td>
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<tr>
<td></td>
<td>Calcium intake</td>
<td>Proportion of population with an intake &gt; 600 mg per day</td>
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<tr>
<td></td>
<td>Total fat intake</td>
<td>Proportion of total dietary energy from fat</td>
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<tr>
<td></td>
<td>Saturated fat plus trans-fatty acid intake</td>
<td>Proportion of total dietary energy from saturated and trans-fatty acids</td>
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<tr>
<td></td>
<td>Sodium intake</td>
<td>Population mean daily intake</td>
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<tr>
<td></td>
<td>Sucrose intake</td>
<td>Proportion of dietary energy from sucrose and other free sugars</td>
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<tr>
<td></td>
<td>Obesity</td>
<td>Proportion of the population with BMI&gt;30</td>
</tr>
<tr>
<td></td>
<td>Full breastfeeding at 3 months</td>
<td>Proportion of infants being breastfed at 3 months</td>
</tr>
<tr>
<td></td>
<td>Breastfeeding at 6 months</td>
<td>Proportion of infants being fully or partially breastfed at 6 months</td>
</tr>
<tr>
<td>To increase the level of physical activity</td>
<td>Physical activity – adult population aged 15 years and over</td>
<td>Proportion of population participating in a minimum of 2.5 hours of leisuretime physical activity per week</td>
</tr>
<tr>
<td>Objective</td>
<td>Current Target</td>
<td>Current Indicator</td>
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<tr>
<td>To reduce the rate of suicides and suicide attempts</td>
<td>Suicides in 15–24-year-old males</td>
<td>Mortality rate</td>
</tr>
<tr>
<td></td>
<td>Suicides in 15–24-year-old females</td>
<td>Mortality rate</td>
</tr>
<tr>
<td>To minimise harm caused by alcohol, illicit and other drug use to both individuals and the community</td>
<td>Alcohol consumption</td>
<td>Annual consumption of pure alcohol per adult aged 15+</td>
</tr>
<tr>
<td></td>
<td>Alcohol-related health outcomes</td>
<td>Age-standardised alcohol-related mortality rate</td>
</tr>
<tr>
<td></td>
<td>Current marijuana use</td>
<td>Proportion of adults aged 15–45 who have used marijuana in the last 12 months and not stopped usage</td>
</tr>
<tr>
<td></td>
<td>Frequent marijuana use</td>
<td>Proportion of adults aged 15–45 who have used marijuana 10 or more times in the last 30 years</td>
</tr>
<tr>
<td></td>
<td>HIV-IDU</td>
<td>HIV seroprevalence rate in sentinel population</td>
</tr>
<tr>
<td>To reduce the disease impact and incidence of cancer</td>
<td>Male lung cancer</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>Female lung cancer</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>Breast cancer mortality</td>
<td>Age-specific mortality rate</td>
</tr>
<tr>
<td></td>
<td>Male melanoma mortality</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>Female melanoma mortality</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>Thick melanoma incidence</td>
<td>Age-standardised incidence rate of melanoma &gt; 1.5 mm</td>
</tr>
<tr>
<td></td>
<td>Cervical cancer deaths – all women</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>Cervical cancer deaths – Māori women</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>Cervical cancer incidence – all women</td>
<td>Age-standardised incidence rate</td>
</tr>
<tr>
<td></td>
<td>Cervical cancer incidence – Māori women</td>
<td>Age-standardised incidence rate</td>
</tr>
<tr>
<td></td>
<td>Cervical cancer stage at detection</td>
<td>Proportion of cases detected at stage 2 or 3</td>
</tr>
<tr>
<td></td>
<td>Cervical cancer stage at detection</td>
<td>Proportion of women enrolled on NCSR</td>
</tr>
<tr>
<td>Objective</td>
<td>Current Target</td>
<td>Current Indicator</td>
</tr>
<tr>
<td>-----------</td>
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</tr>
<tr>
<td>To reduce the disease impact and incidence of cardiovascular diseases</td>
<td>Ischaemic heart disease (IHD) – all males</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>IHD – all females</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>IHD – Māori males</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>IHD – Māori females</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>Stroke – all males aged 65+</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>Stroke – all females aged 65+</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>Stroke – Māori males aged 55+</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>Stroke – Māori females aged 55+</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td>To reduce the disease impact and incidence of diabetes</td>
<td>Diabetes – total population</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td></td>
<td>Diabetes – Māori</td>
<td>Age-standardised mortality rate</td>
</tr>
<tr>
<td>To improve oral health</td>
<td>Population receiving fluoridated water</td>
<td>Proportion</td>
</tr>
<tr>
<td></td>
<td>Percentage of fluoride toothpaste out of all toothpaste sold</td>
<td>Proportion</td>
</tr>
<tr>
<td></td>
<td>Missing or filled teeth in Form 2 children</td>
<td>Average number per child</td>
</tr>
<tr>
<td></td>
<td>Missing or filled teeth in Māori Form 2 children</td>
<td>Average number per child</td>
</tr>
<tr>
<td>To reduce violence in interpersonal relationships, families, schools and communities</td>
<td>Injuries inflicted on children aged 0–14 years</td>
<td>Mortality rate</td>
</tr>
<tr>
<td>Objective</td>
<td>Current Target</td>
<td>Current Indicator</td>
</tr>
<tr>
<td>-----------</td>
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</tr>
<tr>
<td>To ensure access to appropriate child health care and immunisation services</td>
<td>Completed early childhood immunisation all children</td>
<td>Proportion of children with completed early childhood immunisation by age 2 years</td>
</tr>
<tr>
<td></td>
<td>Completed early childhood immunisation – Māori children</td>
<td>Proportion of Māori children with completed early childhood immunisation by age 2 years</td>
</tr>
<tr>
<td></td>
<td>Completed early childhood immunisation – low coverage areas/populations</td>
<td>Proportion of children in low coverage areas/populations with completed early childhood immunisation by age 2 years</td>
</tr>
<tr>
<td></td>
<td>Hearing loss – all children</td>
<td>Audiometry repeat screen failure rate at school entry</td>
</tr>
<tr>
<td></td>
<td>Hearing loss – Māori children</td>
<td>Audiometry repeat screen failure rate at school entry</td>
</tr>
<tr>
<td></td>
<td>Hearing loss – Pacific children</td>
<td>Audiometry repeat screen failure rate at school entry</td>
</tr>
<tr>
<td></td>
<td>SIDS</td>
<td>Rate per 1000 live births</td>
</tr>
<tr>
<td></td>
<td>SIDS</td>
<td>Māori rate per 1000 live births</td>
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<tr>
<td></td>
<td>Infant sleep position</td>
<td>Prevalence of side and back sleep positions at age 6 weeks</td>
</tr>
<tr>
<td></td>
<td>Influenza</td>
<td>Proportion of high-risk population immunised annually</td>
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<td></td>
<td>Burns – all children</td>
<td>Hospitalisations for burns from hot liquids – all children</td>
</tr>
<tr>
<td></td>
<td>Burns – Māori children</td>
<td>Hospitalisations for burns from hot liquids – Māori children</td>
</tr>
<tr>
<td></td>
<td>Swimming pool drownings</td>
<td>Drownings in swimming and spa pools, 0–4 years</td>
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<tr>
<td></td>
<td>Child abuse deaths</td>
<td>Child mortality rate inflicted by other persons</td>
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<td>Hazardous substances – all children</td>
<td>Childhood poisoning hospitalisations for under-5-year-olds</td>
</tr>
<tr>
<td></td>
<td>Children restrained – front seats</td>
<td>Percentage of children aged 0–14 years restrained in front seats</td>
</tr>
<tr>
<td></td>
<td>Children restrained – rear seats</td>
<td>Percentage of children aged 0–4 years restrained in rear seats</td>
</tr>
<tr>
<td></td>
<td>Children restrained – all seats</td>
<td>Percentage of children aged 0–14 years restrained in all seats</td>
</tr>
<tr>
<td></td>
<td>Child seat usage</td>
<td>Percentage of children age 0–4 years in child seats</td>
</tr>
</tbody>
</table>
References


