PHAC

Public Health Advisory Committee

Te Rōpū Tohutohu i te Hauora Tūmatanui

A sub-committee of the National Health Committee

Emerging Issues for Public Health in New Zealand

A Discussion Paper

Public Health Advisory Committee

October 2004

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Purpose of this consultation

This consultation is part of a further collection of information to contribute to Public Health Advisory Committee's (PHAC) advice to the Minister of Health on emerging issues for public health in New Zealand. It reports on what has been said to us in our consultations but with the exception of the "Background" discussion in Section 1, it does not necessarily reflect the views of the PHAC.

The PHAC project does not address the detailed content of specific public health programmes but looks at how public health is organised in New Zealand in a sector that has faced, and is facing rapid change. It asks how the sector can best respond to the new challenges and opportunities this situation presents.

The committee would value input from the traditional public health sector, and also from other newer players and those with changing roles within the sector.

The PHAC seeks your input to help it identify:

- gaps in reporting the views of the sector and issues that need further thought or clarification
- viable proposals that in your view will enhance public health structures and action.

The committee acknowledges that on many issues there will not be consensus, but the more submissions it receives, the better able it will be to judge the strength of feeling and diversity of views on any particular issue. We therefore encourage you to participate.

How to have your say

The PHAC is seeking input from a range of organisations, agencies and individuals from across sectors involved in activities to promote the health and wellbeing of populations and communities and to prevent death and disease. If you are representing a collective view (eg, representing the views of an agency, organisation or community), please make this clear in your submission.

Throughout the document there are questions designed to help you think through your ideas but please do not feel constrained by them. We welcome your input on any level. However, we would ask that you address the two bullet points above to identify gaps in our analysis and to assist development of a way forward.

SUBMISSIONS ARE DUE BY 15 December 2004

Please send your submissions to:

Public Health Oversight submissions
Public Health Advisory Committee
PO Box 5013,
Wellington

Or by email to barbara_langford@nhc.govt.nz or nicholas_huntington@nhc.govt.nz

This document is also available on the PHAC website www.nhc.govt.nz/phac.html

For further information about the project or submission process ph Barbara on 04 496 2084 or Nyk on 04 496 2296.

1 Background

1.1 New context for public health in New Zealand

New Zealand's public health environment is going through a time of dramatic change both structurally and philosophically. The creation of District Health Boards (DHBs) has significantly altered the health sector, giving more responsibility to communities to identify health priorities. More recently, the emerging Primary Health Organisations (PHOs) are required to address not only the health of individual patients, but also the health of their communities.

At the same time, there is increasingly wide recognition that health is strongly influenced by factors outside what is traditionally defined as the health sector. This has led to a re-evaluation of the scope and nature of public health, and the ways in which different bodies and agencies can work together to promote it (the 'new public health'). In the area of local government, for example, recent legislation has given local authorities the ability to define for themselves much wider public health roles than they have traditionally possessed, and also enhanced their ability to undertake actions relating to these roles.

Those with public health expertise and experience are also active in many areas beyond the core public health sector, including in senior management, sector leadership, and research. This enables them to bring a population approach to the orientation and potentially the re-orientation of many health services. In these and other ways, the reach of public health activity extends well beyond its core sector.

This time of shifting roles, responsibilities and structures provides an excellent opportunity for all those involved in public health – from established players to those newly exploring possible public health roles – to reflect on the situation and nature of public health in New Zealand: where it has been, where it is currently, and where it may move to in the future.

1.2 The Public Health Advisory Committee project

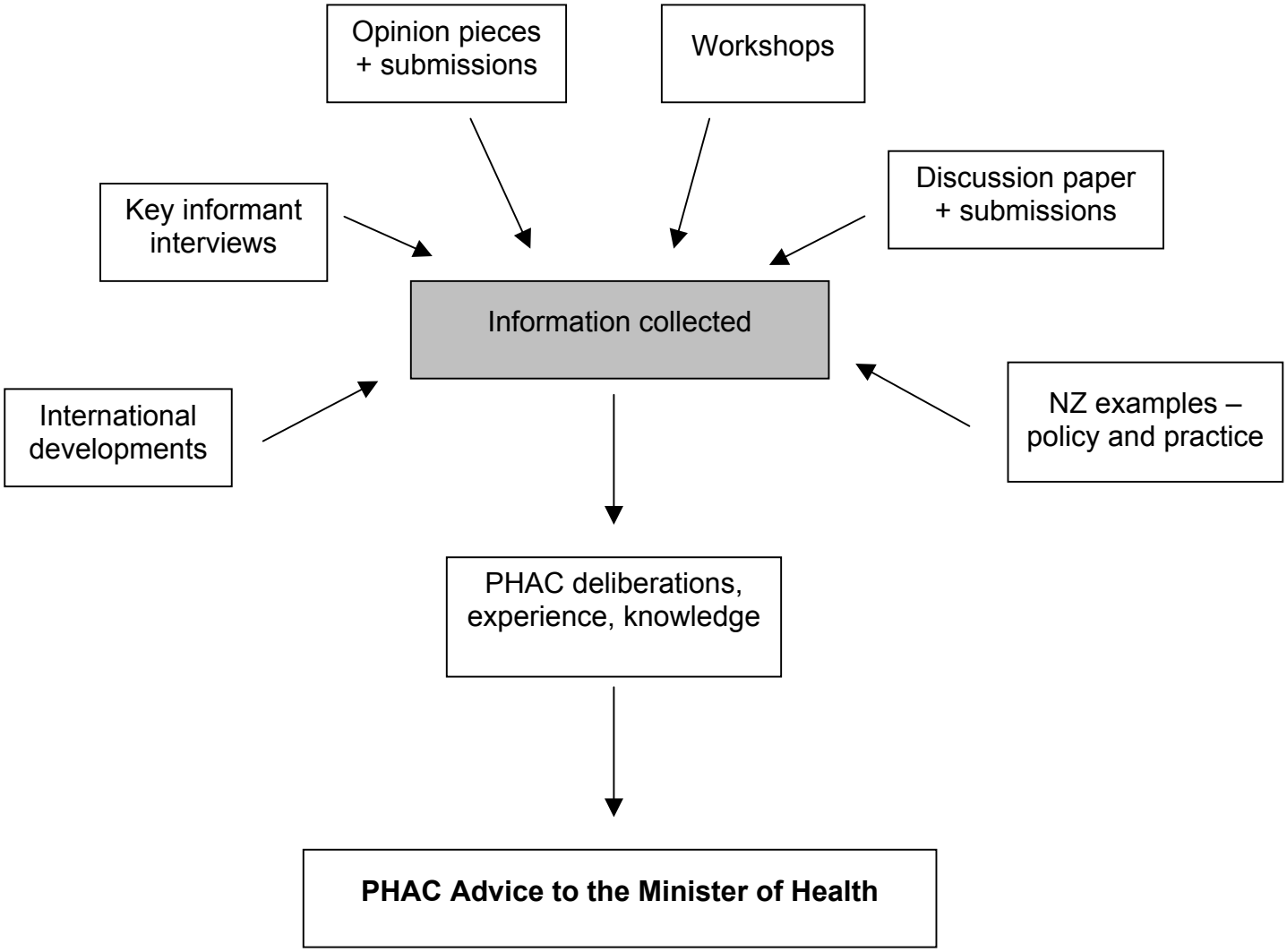
It is this new and rapidly changing environment for public health that is the prime reason for the Public Health Advisory Committee (PHAC) undertaking this project. The PHAC project is exploring how this new environment is impacting on the way that public health is approached in New Zealand, how the new and existing players can take new opportunities to further the goals of public health by their interaction, and how public health capacities and leadership can be enhanced at both regional and national levels. It has also been identifying the challenges that this new environment presents.

The PHAC has conducted around 40 interviews with individuals and groups, both in the traditional public health sector, and with the relatively new players such as PHOs and local government. It has held a workshop at the PHA conference 2004 and has widely distributed five opinion pieces to stimulate discussion. Our thanks for the helpful contributions made during this process and in particular to the writers of the opinion pieces on which much of the background material for this discussion document has drawn.[i]

[i] See http://www.nhc.govt.nz/PHAC/OpinionPieces.html for the five opinion pieces written by Peter Crampton, Phil Shoemack, Robin Gauld, Megan Courtney, and Keri and Mihi Ratima.

The purpose of this discussion paper is to communicate the issues raised through these processes and to invite suggestions for a way forward for New Zealand public health. The paper summarises the views offered so far. The PHAC will report to the Minister of Health early in 2005, making recommendations that draw on this consultation and on other work that it is carrying out. (See Fig. 1)

Fig 1. PHAC process for advising the Minister



1.3 Different views of public health

Different views exist about what public health is. A narrow perspective of "public health" would closely align it with medical and healthcare services (personal health, publicly funded health services) and this is a commonly held view in many other sectors. It is a view that may run counter to an understanding of public health activities as population-centred or population-focussed, and may also run counter to attempts to develop 'whole of government' approaches to improving population health.

A wider perspective acknowledges the importance of the formal health sector but sees the health of the population being even more powerfully affected by a wide range of influences, largely based in other sectors. These are the wider

determinants of health including social, economic, cultural and environmental determinants of health. Beaglehole and Bonita (2004) have defined public health as:

> *"the organised local and global efforts to prevent death, disease and injury, and promote the health of populations."*

This wider view of public health acknowledges that the capacity of any single sector to shape public health on its own is limited. Health improvements across the population and the reduction of health inequalities require intersectoral approaches, involving partnership with the public. This requires a different way of thinking with key roles for public health as catalyst, broker, co-ordinator and monitor as well as in more traditional forms of leadership and advocacy.

Terminology differs across sectors and the term "public health" is often interpreted by other sectors in its narrowest sense, and as being the business of the health sector alone. There have been increasing calls for the use of terms such as "community health and wellbeing" which has more resonance with other sectors. How public health is described and understood will be reflected in the actions organisations and agencies choose to undertake to address the health and wellbeing of their populations.

Some people, particularly Māori, see the separation of public and personal health as artificial – that the two approaches should be seamless. Māori public health includes determinants of health such as economic, social and environmental factors, and Māori identity, access to language/culture, and access to natural resources. It also addresses responsiveness of health services to Māori aspirations.

1.4 Structural change – an influence on public health

Frequent structural change has been a major influence for the past two decades on the way public health in New Zealand functions. The 'new public management', accompanied by sweeping economic and institutional reforms, heavily influenced public policy and administration from the mid-1980s. It was dominated by an emphasis on efficiency and output measures ahead of other performance measures, including those focused on outcomes.

There were advantages and disadvantages in these reforms for public health. The establishment of processes that allowed for the development of Māori Health Providers is seen as a positive result of the reforms. In addition, the establishment of the Public Health Commission in 1992 gave public health a high profile. The fact that it was subsequently disestablished was in part a reflection of the contentious nature of some public health strategies that worked against the narrow emphasis on economic performance.[1]

The reforms also resulted in a proliferation of government agencies and a corresponding fragmentation of services and policy capacity. They also required a rigorous process of contracting and accountability – this legacy remains to the present and has a strong influence on how public health operates.

Recent changes could also be seen to have advantages and disadvantages to the public health sector. The 'Review of the Centre' has resulted in revised legislation to provide flexibility in funding mechanisms to work across government sectors (as opposed to the silo effects of the new public management). The 'Managing for Outcomes' framework that has grown out of the Review of the Centre aims to

reduce the fragmentation in government produced by the 80s reforms. It acknowledges that there are policy issues that do not sit with a single agency (such as child and family issues) and promotes closer interagency collaboration around common long-term policy goals.

At the same time there has been continued fragmentation of public health, especially at a national level. The Ministry of Health lost responsibility for occupational health and safety to the Department of Labour during the reforms. There are indications that while this may have worked well for the prevention of occupational death and injury, the change may not have been effective for occupational health. More recently, the Ministry has lost its food safety and hazardous substances roles to a new Food Safety Authority and Environmental Risk Management Authority, respectively. It is too early to say if these shifts have been effective.

1.5 New players and new approaches to public health

New players in the public health field include local government, with a new statutory responsibility "to promote the social, economic, environmental and cultural well being of communities"[ii]; and Primary Health Organisations, which are required to include "approaches directed towards improving and maintaining the health of the population".[iii] District Health Boards are also still relatively new and are still developing their understanding of public health. Public Health Units (PHUs) have a different relationship with their DHBs from the one they had with their predecessors, Crown Health Enterprises and Hospital and Health Services.

For a summary of the roles and responsibilities of organisations and agencies involved in public health, see Appendix One.

1.6 New approaches and new challenges

Opportunities to address the wider determinants of health have increased with more actors in public health and the potential for intersectoral collaboration. In addition to traditional public health roles, the 'new public health' has required a shift in focus towards the promotion of wider community health and wellbeing through intersectoral collaboration and addressing the wider determinants of health. This shift has brought opportunities and challenges that may require the development of new skills and new organisational capacities.

[ii] Section 10, Local Government Act 2002.
[iii] Minister of Health. 2001. *The Primary Health Care Strategy.* Wellington.

2 Summary of views from first consultations

This chapter summarises issues raised at interviews, workshops and in the commissioned opinion pieces. It does not pretend to represent the views of the whole sector, but of a sample with which the PHAC consulted. It asks you if there are other issues that have not been covered by the previous consultation that you would like to raise. Note that current roles and responsibilities of organisations and agencies involved in public health in New Zealand are described in Appendix one.

2.1 The players in the public health field

This section covers the main issues raised in interviews and other meetings, and by the writers of the opinion pieces, by agency/organisation. The consultation covered the core agencies and organisations involved in public health. However, there are many other agencies whose policies directly or indirectly affect the health of populations and health inequalities that would not consider themselves as part of the public health sector, for example, transport, housing, social welfare and education etc. The consultation has not attempted to cover these agencies.

2.1.1 The Ministry of Health

The Ministry of Health holds public funding for public health. Through the Public Health Directorate it contracts Public Health Units and national NGOs to provide public health action. Public health activities and older people's health and disability services are the only services that have not been devolved to District Health Boards. The functions of the Ministry of Health and its Public Health Directorate are fully described in Appendix One.

Most of the issues associated with the Ministry are to do with leadership and are consequently addressed in the leadership section 2.3.

We received some mixed messages in sector expectations of the Ministry. On the one hand some people in the sector say that the Ministry is not providing strong leadership at a national level, and others say that the Ministry is far too directive, that there is not enough flexibility at a local level. There is a general view that the Ministry role to advocate for the public health is constrained by its constitutional position.

Since most of the PHAC interviews took place, the Public Health Directorate of the Ministry has restructured and created an Office of the Director of Public Health. This office comprises the Director of Public Health (communicable diseases), the Chief Advisor Public Health (non-communicable diseases), the Strategic Advisor Māori Public Health and the Strategic Advisor Public Health Sector Policy and Development (professional leadership). It will however, take time before the effectiveness of the Office of the Director of Public Health can be determined.

Do you have any comments on the issues raised here?

What other issues associated with the Ministry of Health would you like to highlight?

2.1.2 District Health Boards

Many DHBs want devolution of funding for public health because they believe it would allow them the flexibility to more effectively address particular public health needs of their communities. Some feel that some DHBs have disengaged from public health because of non-devolvement. But there is also concern in the public health sector, including some PHUs, that devolvement would bring risks that public health money would be siphoned off to be used in the hospital system. It is commonly believed that this happened in the Area Health Board days.

Those we consulted with report that DHB understanding of and commitment to public health is variable, but is more than likely to be low, especially among elected members. However, there are examples of strong DHB support for public health. The extent of DHB commitment tends to reflect the personal commitment and understanding of senior management and Board members.

2.1.3 Public Health Units

Some Public Health Units report directly to the Chief Executive (CE) of the DHB (eg, Community and Public Health Christchurch, and Regional Public Health, Hutt Valley). Others are situated under the General Manager of DHB Planning and Funding (eg, Nelson-Marlborough, Public Health South, Waikato Public Health, Auckland Regional Public Health Service). The rest are 'provider arms' of DHBs, a carry over from the purchaser-provider split model. From the PHAC interviews, those reporting directly to the CE or to Planning and Funding "capitalise on synergies" and experience more DHB understanding of public health. Those in 'provider arms' tend to feel more marginalised and sometimes experience a conflict of roles between planning and funding, and public health. There is the potential, for example, for both to appear at a local authority hearing with different perspectives.

Most PHUs have responsibility for more than one DHB region but have a primary relationship with one DHB with which they have a contract for delivery of public health services (as well as one with the Ministry). This requires particular relationship management skills to ensure that the public health needs of each DHB region is addressed equally.

Some PHUs have more complex interagency relationship building than others. For example, Waikato Public Health has to relate to three DHBs, ten territorial authorities and one regional council; Tarawhiti Public Health Unit has one DHB and one local authority. South Island Public Health Units have only one iwi to work with; North Island PHUs may have many. This probably means that no one model will fit all.

PHU contracts:

The contracts for the delivery of public health by PHUs have the complexity of two layers – one contract is held with the Ministry and another with the DHBs. Contracts with the Ministry relate to the Minister's priorities. Contracts with DHBs relate to DHB priorities that reflect the particular needs of their communities. There is potential for tension between the two contracting layers. There is a different relationship with the primary DHB with which there is a contract, from that with the other DHBs in a PHU area.

Although there is acceptance that the wider determinants of health have the potential to make the most difference, some respondents felt that Ministry contracts

are focused on the traditional public health issues, which although important, need to be balanced with scope for more innovative approaches that address the wider determinants of health. These contracts are based on the Service Specifications laid out in the Public Service Handbook, which although recently updated, still are seen to have more potential to reflect the cutting edge of socio-environmental work that some PHUs are engaged in.

The need for public health practitioners to work across sectors on the determinants of health requires additional skills. PHUs may be called on to support PHOs in the development of their health promotion programmes, to support councils in Health Impact Assessment, make submissions, and participate in neighbourhood renewal, sustainable development and healthy cities activity. Contracts have not reflected the need for professional development in policy analysis and intersectoral collaboration, although may do once the revised Service Specifications are reflected in Ministry contracts with PHUs.

In spite of this, some Public Health Units, particularly the larger ones, are doing some exciting and innovative work to address the determinants of health. The new local government requirement to develop Long Term Council Community Plans (LTCCP) has opened up new opportunities for the public health sector to make a real difference to council planning. Some are also involved in cross sectoral sustainable development initiatives.

It is felt by many in the sector that contracts with Māori providers need to reflect Māori approaches that do not separate personal from public health. They also need to build in workforce capacity issues and a focus on the responsiveness of health structures to Māori health needs and aspirations. They should build in a capacity to respond to intersectoral work with local government and other parts of the public health sector.

Do you have comments on the issues raised here?

What other issues associated with DHBs/PHUs would you like to highlight?

How does the relationship between DHBs and PHUs work in your area?

How responsive do you think your DHB/PHU is in establishing links with other sectors?

Please describe examples of where public health is working effectively across sectors in your area.

2.1.4 Local Government

New opportunities for cross sectoral initiatives are provided in the new environment, especially in the context of local government reform. The Local Government Act 2002 introduces new requirements for local authorities to consider the health and wellbeing of their communities, to identify desired “community outcomes”, and to develop Long Term Council Community Plans (LTCCPs) that set out how the outcomes will be achieved. The Act requires local authorities to consult with the community to identify ‘community outcomes’. This clearly encourages a climate of collaboration and partnership with key stakeholders including iwi/Māori organisations, community groups, government agencies, DHBs and other local

authorities. The commitment and capacity of the public health sector to work with local government will be key to the successful realisation of the goals of the Act.

Local authorities hold a store of information about their communities, which could be of value to the public health sector. There would be particular value in local government working with DHBs to create combined datasets to which all had access. This collaborative approach would be of benefit to DHB health needs assessment processes and in monitoring the effectiveness of public health initiatives.

There is much enthusiasm in the public health sector for new opportunities for joint work with local government. Public health sector input into the public consultation associated with LTCCPs is identified as a key entry point for public health with community wellbeing and community safety being the public health levers. Some councils are seeking support from PHUs for the assessment of council policies for their potential impact on health. This is an exciting development and has the potential to make a significant difference to the effects of council policies on public health and wellbeing. However, this is a new area of work for PHUs, and skills development in Health Impact Assessment is urgently needed.

Generally our public health respondents report that there is a lack of public health knowledge in local government (especially among elected councillors) and lack of public health and fiscal capacity especially in the smaller territorial authorities (TAs). The traditional approach to public health (provision of sanitation, water quality and food safety standards) still dominates much local authority thinking. Councils where this is the predominant view of their public health role tend to continue with the traditional 'roads, rates and rubbish' approach. Some of the larger councils such as the cities of Porirua, Manukau, Christchurch and Waitemata have taken a broader view of their mandate and have been working on such issues as road safety, injury prevention, community and neighbourhood development and poverty reduction strategies.

There are some barriers to ease of collaboration between DHB/PHUs and local government. Currently there is no alignment of DHB and local government planning processes. Council LTCCPs and DHB District Strategic Plans both have 3 yearly cycles but have different timeframes. This non-alignment is seen to hamper gains that could be made from joint community based planning initiatives between Councils and DHBs.

Another barrier to collaborative approaches is that local government has not been funded to undertake joint activities for community wellbeing. This is in contrast to the UK where $1.5bill of central government funding has been allocated for collaborative interagency work towards community wellbeing.

Do you have comments on the issues raised here?

What other issues associated with local authorities would you like to highlight?

What is your experience of the relationship between the public health sector and local authorities?

2.1.5 Primary Health Organisations

The Primary Health Strategy specifies a population health focus for Primary Health Organisations (PHOs), and this provides opportunities for primary health to adopt public health strategies such as community development and health promotion based on the Ottawa Charter. Since the Alma Ata Declaration in 1978 there has been a growing emphasis on the synergies between public health and primary health and on the importance of community development approaches. There is an increasing body of research literature related to public health and health promotion activities in a primary health setting. The developing interface between public health and primary health through the PHOs, brings opportunities to bring public health and primary health closer together and to work towards common goals of improved community health and wellbeing.

There is fairly widespread agreement that theoretically, linking primary and public health offers significant opportunities for improving public health action. However, there is a feeling that the public health sector may be unwilling to engage with PHOs to some degree. This is seen by some to reflect the fact that the public health sector may be feeling threatened by the requirement for PHOs to have a population health approach, but also some scepticism in the public health sector over whether PHOs have the knowledge, skills, or capacity to undertake any more than patient education and disease management, a traditional health education model of primary health care. Many PHOs are calling this activity “health promotion”.

There are significant professional development needs in this area that will require effort on the part of both the PHOs and the public health sector. There is also a feeling that PHUs will not make a relationship with PHOs a priority because they do not think that is where they can make the most difference to improving health and reducing inequalities. PHOs may show reluctance to share some types of information as a result.

However, some PHUs have appointed dedicated people to work with PHOs on population health approaches, showing that some have a real commitment to assisting PHOs in their understanding of how to address population health at a community level.

Those consulted with suggest that the successful linking of primary health with population-based approaches varies according to the culture of the particular PHO. Traditional bio-medical primary care is the focus of many PHOs and ‘health promotion’ is being defined in these organisations as advice given by the doctors to their patients.

However, there are some PHOs that are collaborations of not-for-profit organisations that have a history of community development and population health approaches, for example, Porirua Healthcare Plus. This history puts them in a better position to undertake effective health promotion in their communities. Some believe that organisations with a community focus have been marginalised in favour of traditional primary care models after joining PHOs who have partners with a focus on the bio-medical model of primary care.

There is some criticism in the public health sector of the funding model used for population health activities in PHOs. The funding level is identified as being very small, and as the only new funding going into public health, it is not going to public health focused organisations or delivered “through a public health lens”. The feeling

is that the population approach will be marginalised in favour of the bio-medical model of health as respondents believe has happened within DHBs and in the Ministry of Health.

Do you have comments on the issues raised here?

What other issues associated with PHOs would you like to highlight?

What is your experience of the relationship between the public health sector and PHOs?

Where are there examples of good practice?

2.1.6 Non Government Organisations (NGOs)

Approximately fifty percent of public health funding goes to NGOs to deliver public health services. This makes NGOs important influences on the delivery of public health, especially as they represent the most stable part of the sector in a time of rapid change. Most are funded directly by the Ministry of Health locality offices (national organisations) but some also have contracts with DHBs.

Public Health NGOs are mainly contracted to provide issue-based health promotion programmes or prevention services (eg, tobacco control, obesity, HIV/AIDS), or population-based such as Māori health, Pacific health or youth public health needs. There are some others that are contracted by the Ministry to address wider public health issues, such as the determinants of health or public health workforce (Public health Association and Health Promotion Forum). These organisations represent collectives of individuals or organisations and are able to represent collective views. They have been particularly active in advocacy to "build healthy public policy". There are some excellent examples of good intersectoral practice involving NGOs, often initiated by the NGOs themselves.

NGO contracts:

There is much anxiety in the NGO sector about recent discussions of their role in public health advocacy. This has significantly affected the activities of some organisations that have a strong commitment to advocacy as one of the most significant and effective public health strategies under the Ottawa Charter ("building healthy public policy"). There is a feeling in the sector that the Ministry of Health has had a knee jerk reaction to criticism and that it has taken too long to resolve the matter. This is seen as having adversely affected the morale of NGOs and hampered their ability to speak out.

However, the Ministry has provided a forum for NGOs to discuss issues of concern. This forum is regarded as helpful.

Do you have comments on the issues raised here?

Is there anything else you would like to say about this issue or about the relationship between NGOs and the Ministry of Health?

2.1.7 Māori and iwi providers

By Māori for Māori health services are models for *tino rangitiratanga* or Māori self-determination in the health sector. Philosophically, public health approaches are seamlessly woven through aspects of *whānau ora* and personal health. However, although funding came from public health money when Māori/iwi provider organisations were first established, it is now largely sourced from personal health money. There is a sense that this has skewed emphasis towards personal health.

Providers define health broadly to incorporate the improvement of Māori health by enhancing natural resources and access to language and culture. Theoretically concepts of Māori public health fit well with the Māori development model but some believe that public health has been missing from Māori development.

There is a feeling that there is a lot of work to be done on how to include concepts of *whānau ora* into public health. Some see it as complementary to public health rather than needing to be incorporated, as it provides the population perspective. There was a suggestion that it could be called *hapu ora* in a public health context.

There are structural barriers to the development of public health for Māori. There is no conjunction between public health boundaries and tribal boundaries; for example, the northern health region cuts Tainui in half. This creates problems, especially for meaningful consultation processes.

Public health workforce capacity issues are high on the agenda for Māori and the need for capacity building, which incorporates strong leadership development initiatives, was clearly identified to PHAC.

Do you have comments on the issues raised here?

What other issues for Māori/iwi public health providers would you like to highlight?

How do you think capacity issues for Māori public health could be addressed?

How do you think concepts of whānau ora could be incorporated into public health?

2.1.8 The tertiary education and research sector

The tertiary sector provides post-graduate training in public health (Diploma and Masters of Public Health, and public health registrar training). Apart from post-graduate training there is very little available for professional development, although there is a now a new module-based Certificate in Health Promotion being offered.

In addition, the tertiary sector provides essential research capacity to the public health sector; essential because of the evidence-based approach that public health takes. There are indications that the research sector could be working more closely with policy-makers to ensure that new evidence is incorporated into policy and that public health research is relevant to policy where appropriate.

However, the tertiary sector has been criticised by some for providing programmes that meet their own research needs rather than meeting the needs of the sector. There seems to be considerable potential for the tertiary sector and public health sectors to work more closely together.

Do you have comments on the issues raised here?

What other issues associated with the tertiary education and research sector would you like to highlight?

2.2 Workforce

There is a general agreement that there is generally a lack of well-trained public health workforce and the new public health environment requires additional competencies. But there is seen to be a general lack of opportunity for professional development in the public health sector. There are also recruitment and retention problems, especially away from the main centres.

Skills required to work on the determinants of health, for interagency work and for evaluating programmes, are different from those required for fulfilling contractual obligations in more traditional public health action areas. Public health practitioners may now be called on to support PHOs in developing their public health programmes and to support local government to assess their policies for impacts on health. They are required to make submissions on a range of factors that impact on health such as urban planning and local government strategic plans. This demands additional individual skills and organisational capacities to those required by the traditional public health roles of health protection and health education.

There need to be more opportunities to develop these new skills. There is a very narrow range of courses and programmes available. They are knowledge based rather than skills based and do not in general provide the skills needed for the new public health.

Other constraints include a high workforce turnover in health promotion, resulting in loss of institutional knowledge; there are not enough trained Pacific people to work with their communities; and there is a need to build Māori workforce capacity.

However, a new initiative from the Ministry of Health is looking at public health workforce development. It has commissioned a survey to identify who is working in public health, what they are doing, what skills and training they have, and what they may need. Already there are signs that tertiary training providers and public health sector are building closer relations.

Do you have comments on the issues raised here?

What other public health workforce issues would you like to highlight?

2.3 Public health leadership

Those consulted believe that leadership can take a number of forms – individual, organisational and community-led. Public health leadership should have impact at national, regional and community levels. All of these forms and levels of leadership need to be fostered. Health leadership is not something that can be left to those working in public health; it must come from all parts of government, the health sector and beyond.

2.3.1 What are the roles involved in public health leadership?

Those consulted have identified the following as roles important in public health leadership:

- provide a vision for public health with a way of achieving this vision, including a vision of how the sector can develop – not just issue based
- increase the visibility of public health issues and raise the level of debate in the community
- build public understanding of and support for public health strategies
- broker public health ideas with other sectors and initiate intersectoral collaboration
- engage decision-makers and the public through evidence-based political and media advocacy
- identify priorities based on evidence and bring together agencies, universities, NGOs, the community and other sectors to address them
- enable others to provide leadership through funding decisions (eg, the Ministry can have an enabling role in the way it funds public health) and sharing of best practice.

Do you have comments on the issues raised here?

What other functions of public health leadership are important?

2.3.2 Where should public health leadership come from?

Parliamentary leadership

Some of those consulted with thought that the first level of leadership should come from Government/Parliament along with an understanding that almost every decision made at national level will impact on health. There are political risks involved in leadership at this level. Legislation and regulation aimed at improving the nation's health invariably attract criticisms of the 'nanny state'. Nonetheless there are examples of good health leadership by parliament such as smokefree environments legislation. Of particular concern to those consulted is that governments have yet to take on board the need to assess all significant public policies for their impact on health. This is the next level of leadership, which the public health sector is hoping will develop.

The Ministry of Health

Another level of leadership comes from the Ministry of Health. One of the Ministry's eight core functions is "providing leadership for public health action".

However, many respondents felt that the Ministry is not able to perform some important leadership roles because its prime role is to support and advise the Minister (along with funding the DHBs to provide health services at a local level). A common belief is that the Ministry's leadership should be strong and autocratic on national public health emergencies, and consultative and enabling on other aspects of public health.

But the Ministry is seen as reactive and that it has difficulty in providing leadership even for national emergencies such as SARS. There is a feeling among respondents that the Ministry response to the SARS crisis was too slow and by the time it provided any leadership, DHB/PHUs had developed their own responses. One commentator suggested that the Ministry is now so focused on policy

development that it no longer has the capacity to lead an emergency situation. The commentator emphasised the need for a national-level organisation that can take this role. There is some hope that the Office of the Director of Public Health, if given some independence, has the potential to make a difference.

District Health Boards

Public health leadership at a district level should come from DHBs, although their focus on service delivery may relegate leadership on key public health issues to a lower priority. Some DHBs show leadership on issues such as fluoridation and immunisation. The feeling is that DHBs need to show their commitment to promoting health and preventing illness in strategic plans. Medical Officers of Health provide some leadership at a local level but DHBs do not have a dedicated 'Director of Public Health' or 'Senior Public Health Advisor' as they would have 'financial advisors' and 'clinical advisors'.

Public Health Units

Public Health Units are seen as the hub of public health action at regional level. As well as their traditional public health roles, some PHUs are leading the way into innovative public health activity that reflects the needs of a rapidly changing environment. Some, especially in urban areas, are establishing teams to address the wider determinants of health and recruiting staff who have the necessary skills in intersectoral collaboration, policy development, health impact assessment, and evaluation. They are forging strong relationships with local governments and getting involved in non-traditional areas such as urban design, housing, and transport policy.

Non Government Organisations (NGOs)

NGOs are seen as being particularly effective as advocates for healthy public policy. The tobacco control NGOs have led the way towards strengthening smokefree legislation to protect all workers from secondhand smoke; HIV/AIDS leadership in the NGO sector has been effective in its campaign to keep the incidence of the condition as low as possible; NGOs have led the way in the fight against cancer and heart disease; and a new campaign to address growing obesity has begun.

Much of their success has been due to their evidence-based media and political advocacy which has built widespread support for healthy public policy measures. Respondents believed that it is crucial that NGOs can continue to advocate for public health at every level.

However, leadership is not just about advocacy and NGOs have also initiated interagency collaboration and community development approaches; have developed partnerships to address the determinants of health and have been instrumental in shifting the thinking around non-communicable diseases away from the medical model towards an Ottawa Charter based approach.

Local authorities

Local authorities were seen to also have leadership roles to play out especially by recognising the potential positive impact that their policies have on health and ensuring that there are no adverse effects on health. They are also in touch with their communities and advocate on their behalf, and are well-placed to initiate effective intersectoral collaboration to improve community health and well-being. There are many examples around the country where local authorities are providing this type of leadership, for example, in Christchurch with the Healthy Cities project; in

Porirua with the Centre of Excellence for Health and associated Health and Information Communication System.

Public Health academics/researchers

At an individual level, public health researchers perform important public health roles through developing new research based evidence for public health action and by speaking out on issues to do with their research findings. However, some of this potential is lost because of the pressures on academics to publish, coupled with their teaching roles. These pressures may preclude their ability to interact effectively with the wider public health sector and the general public. There is no 'professional' organisation taking the lead in public health, such as the Faculty of Public Health in the UK – the New Zealand branch of the Australasian Faculty exists to provide services for its members.

Do you have comments on the issues raised here?

What other public health leadership roles are important?

Other challenges for effective public health leadership

At a national level

Over the past decade or so there has been fragmentation of public health functions at a national level – food safety, occupational health and safety, and hazardous substances are roles that are no longer carried out by the health sector and the Ministry has less influence on the outcomes. The establishment of the Food Safety Authority and Environmental Risk Management Authority are fairly recent and it is too soon to judge their effectiveness. However, it is clear that the separation of occupational health (as distinct from occupational safety) from the health sector has not been effective. This is in direct contrast with the effective result of establishing a separate body to address transport safety, the Land Transport Safety Authority, which has successfully co-ordinated the reduction in the road toll. The main focus of the Occupational Safety and Health Unit in the Department of Labour has been the prevention of occupational deaths and injuries. There is little monitoring or action in the area of occupational exposure to toxic substances or noise, for example, or of the development of occupational diseases.

Another barrier, identified by many, to effective public health leadership in New Zealand is the lack of an independent public health agency at central government level to provide strategic vision, which is provided at the local rather than national levels. The Office for the Director of Public Health may address this in part but it is still an integral part of the Ministry and as such, will have the same constraints on its independence that the Ministry now has.

Do you have comments on the issues raised here?

What kinds of organisational capacities and relationships are required at the national level for effective public health action?

At a regional/local level

The following points were made during the consultation:

- The lack of funding devolution is seen by some as impeding progress and leadership in public health at a local level.
- Regional public health action is hampered in some areas by the locality offices of the Ministry, which also carry out public health activities leading to duplication of effort.
- The importance given to public health by DHBs is variable according to the level of commitment.
- Community and Public Health Advisory Committees (CPHACs) are not being seen as being particularly effective in increasing the engagement of DHBs with public health issues. Many focus on health needs assessment and the delivery of publicly funded health services. The Act does not clearly describe the expected function – "to advise on health improvement measures".

Do you have comments on the issues raised here?

What kinds of organisational capacities and relationships are required at the regional and local levels for effective public health action?

Other structural challenges to leadership

- Many respondents referred to the 'risk averse environment' that public health is currently operating in. District Health Boards have elected representatives, and some do not want to do anything controversial to upset their electorate. The Ministry of Health is bound by the political constraints facing its Minister, and this is seen by many respondents to lead to a sometimes over-cautious approach. And some feel that proportional representation has led to an occasional over-reaction to political pressure. For example, the response to the criticism of advocacy in the Ministry of Health's contracts with NGOs is seen by some in the sector as "using a sledge hammer to crush a peanut." NGOs with Ministry contracts now have to look elsewhere for funding to carry out aspects of public health advocacy. Seen by some, there is also potential for the Public Finance (State Sector Management) Bill to undermine public health advocacy by DHBs/PHUs.

Do you have comments on the issues raised here?

Are there ways in which a broader constituency for effective public health action can be constructed?

- It is felt that there is a lack of fora to link with other public health providers such as NGOs, resulting in many opportunities for collaboration being lost. However, since our initial consultation round, a new forum, the National Public Health Forum, has had its inaugural meeting. The first meeting appeared to attract participants from areas, such as PHOs and community trusts, who have not previously been involved in public health networks. It may be difficult to provide for both these newcomers and to for experienced practitioners who may have different needs.

Another forum is that provided for NGOs with Ministry contracts (not specifically public health). This has been established for some time and is seen to be working well. The Public Health Association has an effective network of individuals and the Health Promotion Forum is a collective of organisations, both with significant participation by Māori. At a regional level, Auckland is the only area to have established a "public health sector reference group", comprising traditional public health providers along with representatives from local authorities and PHOs. This group feeds into a Public Health Steering Group, a partnership representing the funders comprising the Ministry of Health locality office and the DHBs. This model is seen to be working well, providing safe environments for full and frank discussions to take place on issues of common concern.

Do you have comments on the issues raised here?

Do existing national level forums provide sufficient opportunities to develop collective public health action?

At the regional level, should models like the Auckland one be picked up elsewhere or are alternatives required?

What forms of effective leadership are seen to have emerged?

- Some universities are providing research based public health leadership, mostly from individual academics. Academia's independence and research focus provides a valuable environment from which to promote evidence based public health agendas
- NGOs are providing effective evidence based leadership mostly on an issue-by-issue basis. The PHA is seen as providing effective leadership in all aspects of effective public health action but especially on the determinants of health
- A high proportion of the most innovative and effective approaches to public health are seen as coming from the regional and community levels, considered by one commentator as the most powerful place that leadership can occur. In particular, there are many examples of effective intersectoral collaboration taking place. These are effective because they rely on support and trust developed by already established relationships.
- There are examples of TAs taking the initiative in public health; eg., Porirua City Council has taken a leadership role in an intersectoral approach to tackling the priority public health issues for Porirua (diabetes in particular).
- The Ministry of Health provides leadership by developing public health policies and strategies in consultation with the sector; facilitating public health action by funding and there are recent moves to address workforce capacity and development issues.

Do you have comments on the issues raised here?

What other examples of effective public health leadership would you like to highlight?

3 A way forward?

During preliminary consultation through interviews, meetings and workshops, the committee has picked up some suggestions for ways forward for public health in New Zealand. These have been described below. However, the development of this section will be based on the results of this consultation period as well as our other evidence streams. It is therefore deliberately incomplete.

3.1 International models[iv]

When analysing our own organisation of public health in New Zealand, it is important to learn the lessons from international experience and adapt good models for use here. The committee has chosen to showcase three international models that have provided a different context in which public health is promoted and protected.

- **Sweden** has established the National Institute of Public Health. This is an independent public health agency that is required to monitor and report on progress in addressing the components of the social determinants based Public Health Strategy. This means that they will develop indicators for objectives covering economic and social security, childhood conditions and participation in society, along with traditional public health concerns such as protection from infectious diseases and the promotion of physical activity. In addition, most municipal councils employ local health planners and have established intersectoral local public health advisory committees.
- **Australia** has established the National Public Health Partnership to co-ordinate public health action across the states, to reduce the potential for fragmentation and strengthen infrastructure and capacity. Membership includes the federal government, state and territorial governments, the Australian Institute of Health and Welfare and the National Health and Medical Research Council (the latter two do not have voting rights), along with a New Zealand observer. It has an NGO advisory group. The partnership works to raise the public health profile and provides a single voice on matters of national public health importance. It is not a statutory body and exists on the goodwill of its members for any impact it may have. Opinions about its effectiveness are mixed.
- The **United Kingdom** government has positioned public health at the centre of government policy, sparked by leadership from the Faculty of Public Health. There is an increasing emphasis on addressing health inequalities and the determinants of health. Public health now has its own Minister and a Health Development Agency has been established to collate and disseminate information on effective interventions, the public health workforce, and reports from a select committee review of public health. The main focus has been to develop local capacity to meet regional public health needs through Primary Care Trusts, Health Action Zones and Local Strategic Partnerships.

  Primary Care Trusts are similar to New Zealand PHOs and are required to develop a public health team with a Director of Public Health. Similar tensions between public health and primary health as exist in New Zealand

[iv] A fuller summary can be found in Appendix Two of this paper, with an even more complete version available on the PHAC website www.nhc.govt.nz/phac.html

have been identified in the UK, with the public health sector being sceptical of the ability of PCTs to carry out public health roles.

Health Action Zones focus on 26 deprived areas and have an intersectoral approach to public health problems and the wider determinants of health. the community has a say in how funds are allocate. These zones are a major plank to address health inequalities by targeting the most deprived areas.

Local Strategic Partnerships are part of the 'neighbourhood renewal' programme and attempts to bring a range of sector strategies together, health being just one.

Critics have pointed out that focusing on local solutions ignores the fact that many of the determinants of health can only be addressed by national-level policy. Evaluations of all three models have shown mixed success.

Do you have comments on the issues raised here?

What relevance do any of these models, or aspects of them, have for New Zealand?

3.2 Proposals from the consultation process to date

1. **Public health agency**. There is strong support for an independent statutory public health structure with a national leadership role in New Zealand. Options proposed included:
    - *An independent agency modelled on the Swedish Institute of Public Health***.** This agency would have a 'whole of government' approach to the wider determinants of health and other public health priorities. It would be free to provide national leadership in public health, with the Ministry retaining the role of serving the Minister.
    - *The newly established Office of the Director of Public Health be given independence from the Ministry of Health.* This office would have the ability to speak out on public health issues, would provide a visible focus for public health, and give it national credibility and status. It would address communicable and non-communicable diseases, and Māori health in a context of health inequalities and the wider determinants of health. In addition, it could address public health workforce issues strategically.
    - *There is a dedicated Minister of Public Health as in the United Kingdom.*

Do you have comments on the issues raised here?

What are alternatives to the national level options suggested here that should also be considered?

2. **Fragmentation of public health functions, in particular occupational health**. There is no agency taking full responsibility for occupational health in New Zealand. Some of our respondents propose:

- *That options for occupational health responsibilities are explored by an appropriate body and recommendations made to government.*

Do you have comments on the issues raised here?

What are other options or issues to do with occupational health that should be considered?

2. **Workforce issues**. There is widespread concern about skills gaps in the public health workforce that have arisen as a result of recent changes in public health approaches and legislation. Skills in collaborating with other sectors to address the wider determinants of health and health inequalities, in particular, need to be further developed. There are large capacity deficits for Māori and Pacific communities requiring particular skill mixes not provided by tertiary institutions.

   There are generally few opportunities for professional development in public health including leadership development. Opportunities could be increased at little cost by secondments/internships between sectors. However, there would need to be an investment and commitment to providing relevant training across sectors and to building capacity and leadership in particular communities such as Māori and Pacific. Training is also needed for all providers to develop skills in addressing Māori and Pacific health needs. Training on policy-level health impact assessment is essential in the new environment and is so far almost non-existent.

   Some of our respondents propose:

   - *That the current Ministry work to explore public health workforce training and development needs is supported by funding to implement its findings.*
   - *That there is greater collaboration between universities and the sector to ensure that a range of training opportunities meet provider needs in the new health environment.*
   - *That opportunities for secondments and internships across sectors are maximised.*

Do you have comments on the issues raised here?

What are the other workforce options or issues that should be considered?

4. **Public health leadership at a national level.** It is seen as essential that training in public health perspectives is provided for all in the health sector in governance or senior management positions.

   Proposals made by respondents were:

   - *That there are public health training opportunities are provided for those in governance and senior management positions throughout the health sector.*

- *That interaction between academia and policy makers and planners is increased to ensure that new evidence is incorporated into policy and that public health research is relevant to policy where appropriate.*
- *That leadership training is developed, specific to the public health sector.*

5. **Public Health advocacy**. Advocacy for healthy public policy has come largely from NGOs with a single issue focus, but whose advocacy activities may be curbed by changes to their contracts with the Ministry. There is also some advocacy coming from Public Health Units and from individuals in universities.

   Health professional organisations are almost silent on public health issues in New Zealand. It is seen as important that those who have had public health training are given a voice for public health. There is potential for groups like the Faculty of Public Health Medicine to become more outwardly focused and more engaged with the sector. Similarly, there is scope for the Public Health Leaders' Group from the DHBs to develop a leadership role, since the DHB Association (DHBNZ) is seen as showing little interest in or commitment to public health.

   Do you have comments on the issues raised here?

   What are the options or issues to do with advocacy that should be considered?

6. **Ministry contracts**. Public health contracts held by the Ministry with Public Health Units and possibly NGOs, are very disease and lifestyle focused even though public health thinking is moving towards also addressing the wider determinants of health and the development of forms of intersectoral collaboration. Purchasing is considered siloed and reductionist. In addition, contracts do not allow for professional development and workforce capacity building. The proposals made by respondents:
   - *That contracts are revised to create opportunities for intersectoral collaboration to address the social determinants of health*
   - *That contracts are revised to include opportunities for capacity building and professional development*

   Do you have comments on the issues raised here?

   What are other options or issues to do with the regional level that should be considered?

7. **Ministry involvement in public health projects at a district level**. Instances of duplication of effort were described when the Ministry locality offices got involved with hands on public health projects at a district level. There was support for the Ministry being purely a policy-making body at a local level with monitoring and evaluation roles. Hands-on regional public health should be left to the providers. The proposal is:

- *That Memoranda of Understandings are developed between locality offices of the Ministry of Health and public health providers that clearly outline respective roles.*

Do you have comments on the issues raised here?

What are other options or issues to do with the regional level relationship between the Ministry of Health and providers that should be considered?

APPENDIX ONE

Current public health roles and responsibilities in New Zealand

The strong influence that other sectors have on public health means that the institutions and organisations that have a public health role is almost endless. For example, the actions and policies of Government agencies such as the Ministries of Housing, Social Development, and Transport, and Crown Entities such as Housing New Zealand and Transit New Zealand, can and do play an important role in addressing (and, potentially, aggravating) public health needs. Similarly, schools, churches, and private businesses can be important vehicles for promoting public health. Most of these players would not, however, consider themselves part of the health sector, and this section focuses on those "core" actors with specific public health roles and responsibilities in New Zealand.

The Public Health Directorate of the Ministry of Health

The overarching context for public health in New Zealand is determined by the Ministry of Health's Public Health Directorate (PHD). The Directorate identifies its responsibility as being "public health policy and strategy development, including regulation for public health and safety, and the planning and funding of public and population health services," and involving eight core functions:[2]

- Providing leadership for public health action;
- Developing and implementing public health policy;
- Developing and implementing public health programmes;
- Planning and funding public health services;
- Managing emergent health risks;
- Collaborating across the public health sector;
- Leading public health sector development; and
- Monitoring DHB public health and population health performance.

While most of this work is undertaken by the Directorate proper, PHD also maintains four semi-autonomous business units with specific functions: The National Screening Unit, Medsafe, the National Radiation Laboratory, and Public Health Intelligence.[v]

As well as setting the overarching policy direction and developing national strategies, public health is one of the few areas where the Ministry of Health also retains a role in directly funding and managing the provision of services in accordance with these policies and strategies. Following the passage of the *New Zealand Public Health and Disability Act 2000* (*NZPHDA*), responsibility for funding and managing most health services was devolved to District Health Boards. Public health, however, has remained a responsibility of the centre. The Directorate does not itself provide public health services (barring the business units referenced above), but contracts out the

[v] The National Screening Unit plans, funds, and monitors New Zealand's two population screening programmes (The National Cervical Screening programme and Breastscreen Aotearoa) and provides advice on screening issues. Medsafe regulates the use of medicines and medical devices in New Zealand. The National Radiation Laboratory regulates and monitors radiation-related activities, items, and phenomena, and provides advice on radiation-related issues. Public Health Intelligence analyses and monitors indicators of health status for the New Zealand population, and provides information and advice on related issues.

provision of such programmes to Public Health Units and Non-Government Organisations.

To maintain a local presence, the Directorate also operates regional locality offices. There currently exist four such offices, located in Auckland, Hamilton, Wellington and Dunedin. The role of the offices within their region is threefold:[2]

- providing public health sector development and leadership;
- linking public health policy with service provision; and
- managing public health relationships and risk.

As part of these roles, the offices are responsible for managing the Directorate's contracts with local providers in their region. The largest contracts held by the localities are with the 12 Public Health Units (see below), who together account for approximately half of all funding disbursed by the localities. Localities also deal with a large variety of other organisations, however, and in total they administer approximately 450 contracts.

District Health Boards / Public Health Units

Established under the *NZPHDA*, District Health Boards (DHBs) are the main bodies for managing and delivering most health services in New Zealand. Objectives of DHBs under the Act include, amongst others, to:[3]

- improve, promote and protect the health of individuals and communities;
- to reduce health disparities by improving health outcomes for Maori and other population groups;
- to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders;
- to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services; and
- to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services.

Although these objectives do not specifically mention public health, all of them (particularly the first) imply that DHBs must engage in some form of public health action and incorporate a public health perspective as part of their statutory role. To this end, DHBs are required to:

> "assess the health status of [their] population, any factors that the DHB believes may adversely affect the health status of that population, the needs of that population for services, and the contributions that those services are intended to make towards the health outcomes and health status sought for that population."[4]

These Needs Assessments inform the formulation of strategic plans and, from them, annual plans. Although this requirement does not explicitly use the phrase "public health", the Act's reference to "any factors that the DHB believes may adversely affect the health status of that population" clearly requires DHBs to address public health needs and the determinants of health in their assessments. Under the 2000

Act, DHBs are also required to maintain Community and Public Health Advisory Committees:

> "The board of a DHB must … establish a committee, to advise on health improvement measures, called the community and public health advisory committee, and must provide for Maori representation on the committee."[5]

However, the specific nature, work programme, and reporting lines of this committee vary from DHB to DHB.

As noted earlier, public health is one of the few areas where the Ministry of Health retains a direct role in funding services. DHBs are, however, key players in the provision of public health services, as together they hold approximately 50% of the contracts maintained by the Ministry.

Public Health Units

The key vehicles through which District Health Boards provide public health services are through 12 Public Health Units (PHUs). Although each PHU is housed within one DHB, most Units provide services across two or three DHBs. For example, Community and Public Health is managed by the Canterbury DHB, but also works in the West Coast and South Canterbury DHB regions.

Public Health Units may be located in either the "planning and funding" or "service provision" arms of their parent DHBs, or constitute a third arm reporting directly to the CEO. In part, this variance is due to the somewhat ambivalent place of PHUs. On one hand, they are involved in providing public health services and programmes, which implies they should be considered providers. On the other, Public Health Units may also have more strategic functions, such as providing advice on the health needs of populations and contributing to the Needs Assessments noted above, that suggests they are best located close to planning structures.

Public Health Units provide a variety of services, with the specific mix of programmes dependent on the particular PHU. However, the activities of the Units cover all three main aspects of public health: health protection, health promotion, and health education. In addition, PHUs may represent DHBs in particular intersectoral fora, such as the Auckland Regional Public Health Service's membership of bodies such as Auckland's Regional Land Transport Committee and recent joining of the Auckland Sustainable Cities project.

Designated Officers and Public Health Nurses

Although DHBs and PHUs employ a diverse workforce, including public health physicians, health promoters, and generalised analysts, two particular elements deserve specific mention. Firstly are the "Designated Officers": Medical Officers of Health (MOsH) and Health Protection Officers (HPOs). Although employed by District Health Boards, Designated Officers are directly and individually accountable to the Director-General of the Ministry of Health and provided with logistical and technical support by the Ministry.

Designated Officers have a large variety of powers relating to health protection. In particular, under section 70 of the *Health Act 1956*, Medical Officers of Health have extensive powers regarding the prevention of the spread of infectious diseases. To this end, they are authorised to destroy property and animals, appropriate property and materials, prohibit activities, and place restrictions on the movement of people, property and animals. MOsH also collect information from medical professionals on

the incidence of specific diseases within their area of responsibility, which is passed back to the Ministry of Health. Health Protection Officers have similar, but more limited, roles and powers to MOsH.

In addition to the Designated Officers, District Health Boards are responsible for employing public health nurses. The largest single group of public health professionals, public health nurses undertake a diverse range of activities, many of which vary depending on the specific area in which they operate – for example, in the Lakes DHB region, Health Protection Officers have contracted public nurses to undertake disease control.[6] The majority of their role, however, focuses on addressing the needs of children and families.

In this regard, much of their work takes place outside the traditional health sector, in terms of both where they work and the actions they take. In the first instance, public health nurses work mostly by visiting people in their own "spaces", through home and school visits. In addition, their model of practice is intrinsically intersectoral and "wellness-focused" in nature.[7] As well as more mainstream public health tasks, such as health education, immunisation, and disease response, public health nurses also often provide support for families in interacting with social welfare and government housing services, and work closely with social workers and other community workers and agencies.

Local Government

Local government has long had a role to play in New Zealand's public health sector.[vi] Much of this stems from direct legislative requirements, such as the obligation under Section 23 of the *Health Act 1956* for each local authority to "improve, promote, and protect public health within its district." Traditionally, the public health activities of local government have been focused on the health protection aspect of public health, and have consisted of regulatory, monitoring, and enforcement functions in such areas as building, water, and land quality, the regulation of specific professions, and sanitation.

In recent years, however, the potential scope for local government action in public health has widened considerably – primarily due to the passage of the *Local Government Act 2002*. In the first place, the Act now defines the purpose of local government as being "to promote the social, economic, environmental, and cultural well-being of communities, in the present and for the future."[8] Section 77 also requires that all local government decision-making processes include an assessment of how a given action will impact on these different forms of well-being. While this does not specifically reference public health, the potential for a strong relationship between the health (personal and public) sectors and local government is implied.

Perhaps more important, however, are the Act's changes to local government's capacity for action. Historically, local government in New Zealand operated under a prescriptive model – if a council wished to take an action, however minor, it could only do so if there existed legislation specifically authorising that action. 2002 saw

[vi] Local government in New Zealand consists of 74 City and District Councils (territorial authorities), and 12 Regional Councils. Five territorial authorities (the Chatham Islands Council, Gisborne District Council, Nelson City Council, Marlborough District Council, and Tasman District Council) also have regional council functions. Regional councils are concerned primarily with regional environmental management, transport, and civil defence, while territorial authorities deal with more local issues, including community wellbeing and recreation.

the reversal of this approach in favour of an enabling model. Legislation now sets out specific things that councils must do or provide and specific actions that councils cannot take, but within these boundaries authorities have extensive freedom and flexibility. In order to assist with this, councils are required to, in consultation with the community and other relevant bodies, identify desired "Community Outcomes", and develop Long Term Council Community Plans that outline how these will be achieved.[vii]

These changes surrounding local government may have an important impact on the role of territorial authorities and regional councils in public health. While the traditional regulation and enforcement roles of these bodies remain, they also now have the freedom to engage in other public health activities. However, it should be noted be noted that this is purely a potential outcome of the 2002 Act, and there is no obligation on councils to explicitly address public health needs.

Primary Health Organisations

Established under the *Primary Health Care Strategy* (2001), Primary Health Organisations (PHOs) are groups of providers whose main concerns are the primary health needs of the people enrolled with them. The group will always include a GP and may also include nurses, Māori providers, Pacific providers, pharmacists, dieticians, mental health workers, community health workers, and dentists.

The PHO model of healthcare is thus a holistic one in which public and personal health care are both positioned within an overall population healthcare approach. As well as making "sick people well", PHOs are charged with maintaining and improving the health of the communities they serve.[9] To this end, the formulae that guide the allocation of funding to these Organisations include a specific amount intended to be used for health promotion activities.[viii] These programmes can be carried out directly by PHOs or in collaboration with other organisations and providers. District Health Boards are required to monitor and approve PHO health promotion plans before Organisations receive this funding.

Non-Governmental Organisations

Non-Governmental Organisations (NGOs) are key components of New Zealand's health sector. Although highly diverse, this "third sector" has two main roles in regard to public health. Firstly, most individual NGOs provide specific health promotion and education services, such as tobacco control or wellchild programmes. Many of these are funded through Ministry of Health contracts, with NGOs responsible for the half of public health contracts that are not held by Public Health Units. In addition, several organisations also provide public health services independently of the Ministry, including a number of large NGOs that receive no government funding.

In addition to this provision role, NGOs play a vitally important advocacy role. This sector is a critical player in the policy networks that surround public health in New

[vii] A detailed description of the changes made by the 2002 Act and the Community Outcomes and LTCCP processes may be found in Local Government New Zealand, 2002, *Beginners Guide to the Local Government Act 2002*, Local Government New Zealand: Wellington.

[viii] At the time of writing this funding was determined according to a base rate of $2 per person enrolled with that PHO, with additions to this rate based on NZDEP rating and ethnicity of the specific person being counted. This is the same irrespective of the PHO's status as an Access- or Interim-formula funded Organisation.

Zealand, by providing a dedicated and independent source of information and leadership on specific issues. This involves highlighting and commenting on relevant issues in the media and to policy-makers, monitoring public health performance, undertaking and commissioning research, providing a collective voice for practitioners and those whose needs they serve, and providing advice on policies that may impact on their areas of concern.

Māori and Iwi Providers

Māori and iwi providers are a part of the NGO sector deserving of specific mention. These providers deliver health services from an explicitly Māori perspective and, usually, specifically by Māori for Māori. This allows public health programmes to be designed and delivered in a culturally appropriate way, and therefore increases their effectiveness in addressing the public health needs of Māori.

A variety of such providers exist some of which, such as Tu Kotahi Māori Asthma Society, deal with specific health issues, but many of whom incorporate the delivery of public health services within a wider model of Māori-centred health and development services. Of particular note in this regard is that many Māori and iwi providers deliver services across both the public and personal health sectors. This may be at least partly due to traditional Māori concepts of health, which do not draw as great a distinction between these areas as modern Western concepts.

The Tertiary Education and Research Sector

Tertiary institutions have two important roles in New Zealand's public health sector.[ix] Firstly, they provide specialised public health training. This includes specialist programmes in public health (including specific aspects such as environmental health or health promotion) at both degree and post-graduate level, and the increasing incorporation of public health-related courses in other pre- and post-registration education programmes for nursing and medical professionals.
In addition, the tertiary sector is a source of research and knowledge that assists in identifying public health needs, evaluating existing or potential public health programmes, and formulating new approaches to addressing public health needs. This may lead to some research projects, such as those using an action research methodology, in which researchers become directly involved in developing public health programmes and services.

Public Health Medicine Specialists[x]

There are approximately 100 active public health physicians in New Zealand who practice at least 50% in Public Health Medicine; a further 32 registrars (full time equivalent) are currently in the four year Training Programme.

In 1997 a workforce profile was undertaken, which identified four distinct areas of current practice:

[ix] Although the tertiary sector consists of a vast array of programmes and providers, the main institutions with an interest in public health are universities and polytechnics.
[x] From the Australasian Faculty of Public Health Medicine website http://www.afphm.org.nz/main.html?pubhealth.html~body accessed 21 Oct 2004

- High level planning, purchasing and management: one quarter of the public health physician workforce is engaged in this area, mainly in the Ministry of Health and in the divisions of the Health Funding Authority.
- Public health service provision: one third of the workforce is engaged in the delivery of public health. Most are associated in some way with the public health units in Hospital and Health Services.
- Academic public health: one quarter of the present workforce are employed in academic positions where they have research, teaching, advisory and management responsibilities.
- Consultants and clinicians: a number of public health physicians are self employed as consultants working under contract in a variety of areas. Currently this number is probably less than 10 but is growing. In addition, approximately 10 public health physicians are working in mainly clinical settings, particularly general practice and occupational health.

The Faculty exists to provide education and training specifically for its public health medicine specialists. It does not tend to address wider public health issues.

The Public Health Advisory Committee

The Public Health Advisory Committee (PHAC) is an independent committee established under Section 14 of the NZPHDA to advise the Minister of Health on public health-related issues. A subcommittee of the National Health Committee, the PHAC pursues a varied work programme and has a statutory obligation to develop its advice after consultation with appropriate individuals and organisations. Recent work by the Committee includes advice to the Minister on the use of Health Impact Assessment and documents to assist in such assessments, and reports analysing environmental and economic determinants of health.

APPENDIX TWO

International Context[xi]

Rather than attempt to represent a global picture, three countries are represented here in which recent developments have altered the context in which public health is protected and promoted: Sweden's recent moves to make the wider determinants of health a more concrete focus of public health policy, Australia's development of the National Public Health Partnership to promote collaboration between bodies with a statutory responsibility for public health, and the United Kingdom's development of intersectoral community initiatives within the context of a wider reconsideration of the structures concerned with public health.

Sweden – focusing on the wider determinants

In recent years Sweden has taken a lead in recognising the wider determinants of health in policy development. In 2003, following the work of a National Public Health Committee that included representatives of all political parties, labour organisations, researchers, and particular communities, the Swedish government established a new set of 11 overarching objectives for public health. While five of these objectives focused on traditional public health concerns, such as ensuring effective protection against communicable diseases and promoting physical activity, the other six included such wider concerns as promoting economic and social security, secure and favourable conditions during childhood and adolescence, and participation and influence in society.[10]

The National Institute of Public Health (NIPH) is required to develop performance indicators for these objectives, and report regularly on progress. This shift toward actively reporting on the determinants of health within a public health framework builds on a strong basis of inter-sectoral collaboration at local levels.

In addition, local government has become increasingly involved in explicitly addressing public health. Most municipal councils now employ local health planners and have established intersectoral local public health advisory committees.[11]

Similarly, the "Healthy Cities" model promoted by the WHO has proved popular, and multiple networks between councils have been developed to support this.

Australia – the National Public Health Partnership

Historically, public health in Australia has been the responsibility of individual states. Although the federal government has played a limited role in public health policy, states and territories have been the dominant players in developing and implementing local policy, disease surveillance, and the regulation and enforcement of public health standards within their own region.[12]

While such an arrangement preserves state autonomy, it also has the potential to lead to significant fragmentation within the country if different jurisdictions pursue different goals and use different approaches. In 1996 the National Public Health Partnership (NPHP) was created to address these tensions.

The Partnership consists of the federal government, each State and Territorial government, the Australian Institute of Health and Welfare, and the National Health and Medical Research Council (the latter two bodies do not have voting rights). One

[xi] A fuller description of these international developments can be accessed at http://www.nhc.govt.nz/PHAC/phac_pubs.html

senior representative from New Zealand has observer status. The Group also maintains a separate NGO Advisory Group to act as a conduit for information between that sector and the Partnership. Recently, arrangements have also been made to include a representative of local government.

The Partnership has four objectives:[13]

- identify and develop strategic and integrated responses to public health priorities to guide and support governments and service providers
- establish two-way exchange with key stakeholders on the development of national public health priorities and strategies
- develop better coordination and increased sustainability of public health strategies
- strengthen public health infrastructure and capacity nationally.

The work of the Partnership is conducted through working groups dedicated to specific areas, each of which contains representatives from each of the Partners and other relevant bodies. These areas include nutrition, environmental health, public health information, and workforce development.

The NPHP is not an independent statutory body that tells others what to do, nor does it possess powers beyond and apart from those possessed by its members. It acts as an entity that allows its members to communicate, coordinate activity, speak in unison on public health matters. This model is less politically threatening than others, as it preserves the fundamental autonomy of those involved.

The Partnership also works to improve the overall visibility and legitimacy of public health in Australia. Of particular importance here is that, while the NPHP is an inter-governmental body, it includes significant representation from the NGO sector (including public health professionals), and now local government. This both provides a method whereby these sectors can improve their own links with each other, but also creates a direct link between the practice (including researchers and those who experience public health needs) and policy levels.

Of course, for the benefits of this model to be realised there must be a commitment on the part of those involved in the Partnership. As the NPHP has no actual powers, and exists via a Memorandum of Understanding rather than statute, it relies more than other models on the goodwill of its members for it to have any impact. While this does not appear to have been a major problem in Australia, the same preservation of autonomy that makes it a politically attractive arrangement also leaves it vulnerable if participants choose not to engage in good faith with the Partnership.

The United Kingdom: Promoting intersectoral collaboration

The 1997 accession of the Tony Blair-led Labour government has sparked a repositioning of public health at the centre of government policy. One of the strongest themes in the proposed “modernisation” of the National Health Service (NHS) has been an increased focus on public health, including an emphasis on the need to address inequalities and the determinants of health.

The actions taken by the Labour government to promote the new public health agenda have been diverse, including the creation of a Minister of Public Health, the establishment of a Health Development Agency to collate and disseminate

information on effective interventions, moves to diversify the public health workforce, and reports on public health from a Select Committee review and the NHS' Chief Medical Officer of England.

The dominant feature of Labour's approach to public health action has been an increasing focus on developing local capacity to meet regional public health needs. This has taken two main forms: building public health into Primary Care Trusts (PCTs), and the promotion of Health Action Zones (HAZs) and Local Strategic Partnerships (LSPs).

Primary Care Trusts are key elements of the "new" NHS envisaged by Labour, and are responsible for coordinating the provision of health services for a particular region. As part of this, each Trust is required to establish a public health team, and employ a Director of Public Health who sits on the managing Board of the PCT.

It is probably too soon to fully evaluate the effectiveness of this model in addressing local public health needs. However, while recent case study research found strong commitment on the part of PCTs to their public health role, it also identified significant variation between Trusts in steps taken to actually address public health needs, and the existence of some tension between the public and primary health branches of particular Trusts.[14] The public health sector is somewhat sceptical of the public health role of PCTs.[15]

The second main arm of this localised approach has been the development of Health Action Zones and Local Strategic Partnerships. The first of these, HAZs, are focused on addressing the health needs of the 26 areas in the UK defined as most deprived, and bring together NHS services (such as PCTs), local authorities, communities, business and voluntary organisations, and social services to address both the direct public health needs of those communities (such as programmes for Coronary Heart Disease and preventing drug abuse) and wider determinants of health, such as education and employment.[16] These Zones are intended to be a major element of the government's strategy for addressing health inequalities, by directing funds specifically toward the most deprived communities and giving communities the ability to determine how these funds should be allocated to support community development.

Local Strategic Partnerships were developed as an element of the government's general commitment to "Neighbourhood Renewal", and this strategy places health as one element of a series of equally important sectors, each of which contributes to the others. Whereas HAZs are focused on a specific policy outcome, LSPs are more like umbrellas designed to bring various local strategies into a coherent whole.

Several critics have argued that focusing on local solutions ignores the fact that many determinants of health can only be addressed by national-level policy.[17,18] Recent evaluations of these initiatives have, as with similar research into the public health role of Primary Care Trusts, presented a mixed picture of their success.

While it appears that development of Health Action Zones has been influential in promoting awareness of inequalities and the social determinants of health, achievements have been relatively small and their impact unclear.[19] Similarly, an interim[xii] evaluation of the LSP initiative has identified significant variation in

[xii] A full evaluation of the LSP model is due to completed in 2007.

efficiency and effectiveness between particular partnerships with those where the new arrangements built on existing models being most successful.[20]

Recent research commissioned by the Faculty of Public Health suggests that while overall commitment to inter-sectoral work in public health is strong, there is little clarity as to how different players should be interacting with each other.[21] The results of this research: the Raising Health report, identified several methods for improving collaboration, most of which revolved around the theme of improving arrangements and information-sharing between players, and clarifying the roles of these players. Importantly, the report also noted that supporting local development does not absolve national government of its own public health responsibilities, and that "not everything can be left to local and regional level."[21]

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