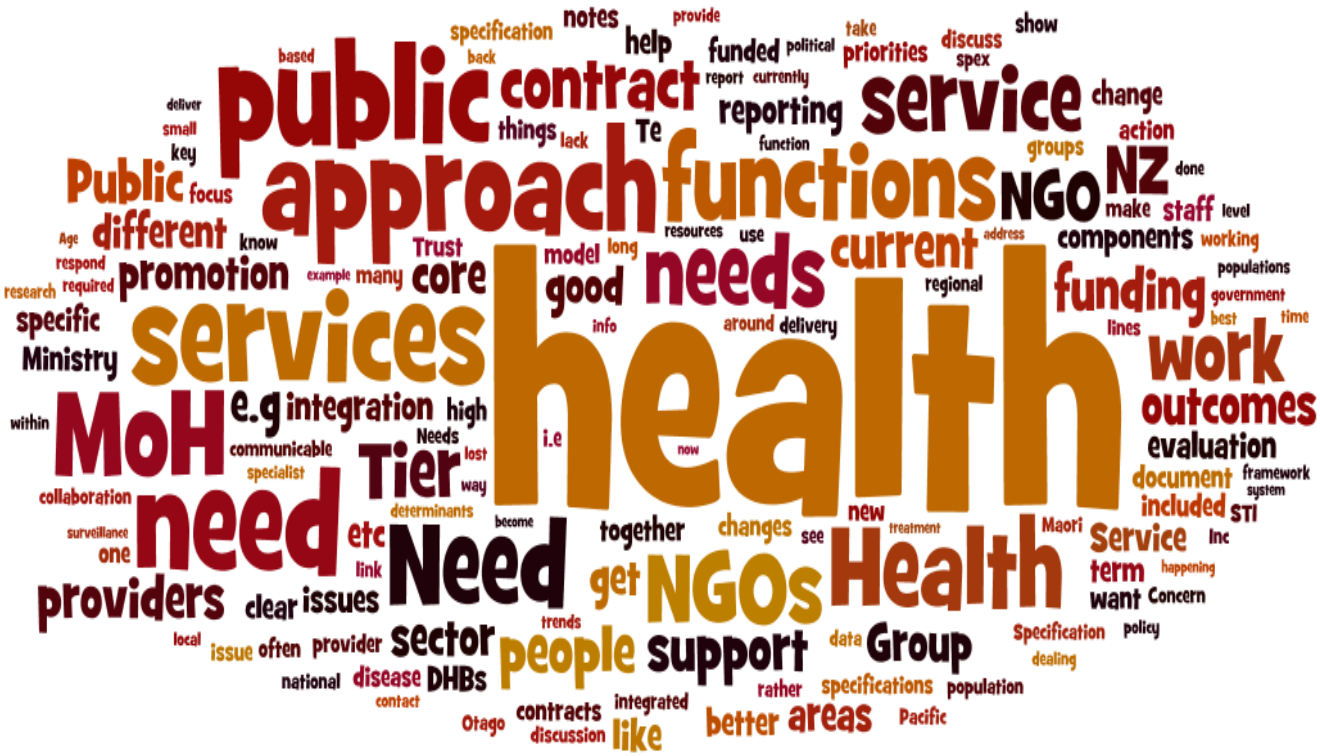

Compilation of feedback from Public Health NGO Engagement Workshops to discuss Tier 1 Service Specification – June/July 2012

Background

The Health and Disability NGO Working Group organised and hosted four workshops in June and July 2012 so key Ministry of Health staff could gain insight from non-profit public health providers before they began revising the high level Public Health Tier 1 Service Specification.

The workshops were held in Auckland, Wellington, Dunedin and Christchurch. Invitations were mailed to 282 addresses using details supplied by the Ministry, however 101 of these were in locations some distance from the workshop venues, so were unlikely to attend.

A total of 52 people from 44 NGOs participated in the events. An additional 26 people registered to attend, but had to withdraw for various reasons.

At each event, an introductory presentation was followed by discussion in small groups. This centred around three key questions:

- What are the good and not-so-good aspects of the current Tier 1 specification?
- What are your thoughts on an approach that would reduce the 13 service components to 5 core functions?
- What changes/improvements would you like to see?

Themes common across various workshops

Although expressed in a variety of ways, some ideas and issues arose at more than one workshop. These included the following:

- There is a need to share simply what public health is. People talked about having a clear vision or description that everyone could understand and 'buy into'.
- Passionate providers, who were very committed to doing the right thing, wanted others (funders, the public, the rest of the health sector) to see the value of public health.
- Many felt public health and health promotion were currently under-valued because of difficulties showing tangible outcomes in the short to medium term.
- We need to get better at measuring public health outcomes and then sharing these. There was support for connecting services to short, intermediate or long term outcomes.
- The non-profit sector is keen for more engagement with the Ministry and would like to help develop the way forward together.
- Providers want to work in a linked up, integrated way – with other public health providers, the rest of the health sector and those in the broader social sector to address determinants of health (e.g. housing, justice, etc). Competitive funding models did not help with this.
- There was a desire for national consistency, but regional/local flexibility – some highlighted examples where messages in high profile national campaigns were not connected to local initiatives.
- The specification should make different populations more visible and recognise they have different needs and will respond differently to different approaches.
- Providers liked the neutrality of MoH funding public health services rather than DHBs that are also providers.
- A comprehensive combined approach that showed service components AND core functions was wanted in the Tier 1 – not an either/or approach. People talked of a cross-cutting matrix concept. There were significant concerns about losing current service lines completely and key health issues becoming invisible.
- The impact of the National Services Framework and the relationship of the Tier 1 Service Specifications to contracting were not well understood by most attendees, so the workshops provided useful background for future consultation.
- The Tier 1 Public Health Service Specification on the National Services Framework website is not very prominent and does not stand out well, so improvements to the site would be useful.

Notes from Auckland Public Health Engagement Workshop to discuss Tier 1 Service Specification – 25 June 2012

Key points from report back

- Current funding focus on 13 areas is quite narrow – difficulty in funding appropriately.
- What about a holistic approach?
    - Ottawa Charter – model from top
    - Need clarity – what is it?
    - Where does public health agency sit?
- Need a compelling vision – Tier 1 needs to sell the message. Communicate up and outwards to the community so people get it – see it and feel it in their everyday lives – don't baffle with jargon.
- Pros and cons to functions approach – need a matrix approach to ensure areas don't get lost.
- Challenge of dealing with MoH & DHBs – multiple contracts.
- Should be contracting for outcomes, not outputs.
- 5 functions? – what does this mean for specialist services? Are they 5 separate funding pots?
- More determinant approach needed – esp. for Māori and Pacific.
- Health funding tends to go to what's in vogue.
- Will this put more specialist services under pressure?
- How will services work with 5 functions?
- What about integration between Ministries?
- Need an integrated govt approach – service linkages.
- Ensure wording is not focused on a clinical setting – needs to be crafted to encompass health promotion.
- Most health promotion actually does four of the five function areas (except health protection) – so it is not necessarily valuable to split out the functions.
- Still need specialist training requirements if broadening scope.
- Add a review date.
- Specify outcomes to be achieved and by whom.
- Need clarity about funding – what are we funded for?
- Tier 1 definitely needs to be updated.
- Currently has a narrow illness focus (e.g. Age Concern funded under injury prevention.)
- How can we work together? Suggest national links.
- Themes to cover: catering for future change, contract negotiations, reporting.
- Need a 'living' document that is flexible.
- Need to be working from evidence based approach – are we funded for this? Research and evaluation not often funded.
- How can the document support cross sector work and integration?
- Need system that is for "ongoing work", not short term.
- Concern about a lack of strong public health policy/discipline.

- Risks associated with a thematic approach – areas likely to get lost. At least a commitment to funding 13 areas at the moment. Will this be there if shift to 5 functions?
- Health promotion has matured in this country – to a point where some intermediate outcomes could be incorporated.

Group 1 notes

- Need good feedback loop with MoH. Does tier system allow for this?
- Does framework document support the limited resources of NGOs?
- Does it provide support from MoH?
- How does it support cross sector work?
- How does this facilitate work with other sectors?
- Does it support good preventative health systems?
- Needs to reflect value of NGO systems.
- Needs to reflect challenges of working with other sectors.
- Like idea of bringing about change in tiers to reflect change in our work.
- Need more integration – accountability between organisations to all contribute to outcomes.
- Need plan for sector – we need to be funded for ongoing work – follow on – so we can show public health works. Framework documents need to support this.
- Is this encouraging progress?
- 13 lines is a good way to fund (clear).
- Does not show how they all link up with each other.
- Can strengthen lines with more up-to-date core functions – issue areas.
- Matrix approach needed – that reflects issue areas and cross overs – could help with integration/collaboration/whānau ora.
- Don't want detail taken away in Tier 2. What will Tier 2 look like under a functions approach?
- Priorities have changed – priorities need to be included.
- How do we cater for future change?
- The spex should support contract negotiations and reporting.
- Make it a more living document – needs to allow for review.
- Play to our strengths – system needs to support this. Document needs to not create barriers to this. We need leadership from experts in particular areas, but still make room for small NGOs that are connected to their communities.
- Research/evaluation – we need more resources to do what we know is best. Does document support this?
- Needs to include a strategy too.
- Common themes everyone wants, but also room to specialise.
- Don't want to be restricted, want to be able to take risks – can't be too prescriptive.
- Fear loss of focus in some areas (esp. if shift to 5 functions approach).
- NGOs are good at using their own creativeness to work together, get things done.
- Inclusiveness – must incorporate. Not constraining.

- Outcomes framework useful – need to be progressive, needs to show progress so we can challenge MoH on why outcomes are not being met.
- Health promotion korero needs to be stronger – where is policy? Where is the strong sector language to show health promotion theory/practice?
- Some concern that the workshop is called 'pre-engagement' but there already seems to be a commitment to the 5 functions option.

Group 2 notes

What do you think about the current approach/purchasing?

- Narrow
    - Illness model
    - i.e. Age Concern would fit better under health promotion
    - fits 2-3 core functions
- Ottawa Charter needs to be modelled from the top
- Better clarity about what we want and how.
- Questions:
    - Where does the Health Promotion Agency sit?
    - Are the 5 core functions linked to funding?
- Tier 1 needs to be updated.
- What are we funded for?
- Show how we can work together more/natural links.
- Cater for further change/contract negotiations/flexibility.
- Work from evidence based system/research/evaluation.
- NGO can specialise in areas.
- Risks associated with thematic funding approach.
- Need cross-sectoral approach.
- Does it support a good preventative health system?
- Ongoing work/follow-up.
- Public health policy – detail is good.

What do you like?

- Accountability
- Holistic approach
    - ✓More focus on wellness (not illness)
    - ✓Quality of life
    - ✓Family health
    - Providers having a holistic view and modelling it at a high level.
    - An integrated approach – DHBs with NGOs – need to work better together.

Change and improve

- Language used – needs to be understood by everyone.
- Make reference to models of health.
- New measures of well-being/GDP – developments that are local.
- A vision that communities can buy into from the beginning.

- Positive health/psychology models link back into Māori health – i.e. I'm healthy because I'm happy!
- Identify service linkages.
- Whānau ora approach/integration (clinical/NGO Forum).

Group 3 notes

- When dealing direct with MoH, process appears to be easier. Difficulties arise when dealing indirectly through DHBs etc.
- Contracting for outcomes rather than outputs.
- What does it mean for specialist services? (The move to 5 core functions.)
- Ensuring stability of funding?
- Allows Māori and Pacific services to have a more determinants approach.
- Concern over loss of smaller providers.
- Funding is fashion oriented – whatever is in vogue.
- Willingness to move from 13 to 5 but concern with how sectors will be covered under the five.
- Descriptor does not match the component.
- Difficult to show results in health promotion.
- Agencies required to further their scope to become more integrative in their approach/ service delivery. Concerns about ensuring capacity/resource/training.
- Will integration mean integration amongst Ministries?
- Tier 1 service components would benefit from an integrated government approach (e.g. MoH, MoE, Justice, etc.)

NGO Attendees

Alison Stanton	La Leche League NZ
Anna Bailey	Health Star Pacific
Bev Pownall	NZ Lactation Consultants Association
Chris Harris	Spectrum Care
Deb Petersen	Te Korowai Hauora o Hauraki Inc.
Eileen Kelly	Rape Prevention Education
George Parker	Women's Health Trust
Isis McKay	Women's Health Trust
Janferié Bryce-Chapman	Age Concern North Shore Inc
Judi Clements	Mental Health Foundation of NZ
Julie Radford-Poupard	Women's Health Trust
Leonie Matoe	Te Hotu Manawa Maori
Natalia Valentino	Arthritis NZ

Nick Laing	NZ AIDS Foundation
Rebecca Williams	Alcohol Healthwatch
Saffron-Moana Middleton	Te Rapakau Pacific Trust
Sylvia	Rape Prevention Education
Tanya Suin	Chinese Action Network-Bridging Trust & Community Social Worker in Palliative Care
Victoria Larbalestier	Doctors for Sexual Abuse Care
Wynae Tukere	Nga Miro Health Centre
Zoe Hawke	Hapai Te Hauora

Notes from Wellington Public Health Engagement Workshop to discuss Tier 1 Service Specification – 26 June 2012

Key points from report back

- Need clear definition.
- Short, medium and long term outcomes for public health would help us articulate what public health providers do.
- Need to create a platform for services to be developed.
- This is an opportunity to describe a scope of work and clarify what public health is about.
- Need to quantify what is done.
- The current 13 service descriptions are not very clear or encompassing – need to be clearer.
- NGOs are very diverse in terms of size – need spex that all can relate to.
- Need interim outcome measures that follow a programme logic.
- Need to think carefully about why a functions approach might be better than the current 13 areas. Need a robust process to switch – weigh up advantages and disadvantages.
- Concerns about what may be lost if only a functions approach – potential to lead to more separation.
- Combine both functions and components – not an either or.
- Need clear language, robust criteria.
- How can the Tier 1 help public health be better integrated with the rest of the health sector – often stands alone currently.
- Need integration with other departments to address social determinants of health.
- Could articulate a vision for all people, rather than target specific deprived populations – set out what all people should have then work to get there.
- The proposed 5 functions seem very disease focused – not a wellness approach.
- Need to promote integration – a combined functions and components approach is needed. Using only a functions approach could make the system more fragmented – perhaps put the functions under the service descriptions or take a cross-cutting approach.
- Need to ensure specifications don't make it easy for DHBs to just contract with themselves and PHOs – needs to be inclusive.
- MoH needs to have a strong policy function.
- Funder and provider roles need to be clearer and stronger – dual accountability.
- Need a KPI for each service component.
- Although several overseas models use the functions approach, we need to recognise that the international context is not the same as NZ where we have DHBs that are funders and providers.
- Needs strong leadership.
- Need joined up planning and implementation.
- Need more partnership between NGOs and DHB provider teams.
- Some collaboration is already happening (e.g. skin infections) – how can the specifications capture and encourage this, and how services are delivered?
- New spex need to take account of key documents/programmes that provide a wider context for our work – e.g. Ottawa Charter, Whānau Ora, Kia Tutahi Relationship Accord,

merger of ALAC and HSC in new Health Promotion Agency, etc. What are the short and long term implications of these?
- Oral health seems to be an omission in the current 13 areas – this is an example of how an issue can become less visible – making it harder to see what is happening. A danger that other issues will also become less visible if only a functions approach taken.
- The current specification is very readable – we need the new one to be likewise.
- What about convening an expert advisory group together to help develop the new draft Tier 1 specification? (As was successfully done for the mental health specification).

There was a request for an electronic copy of the core functions paper produced by the Public Health Clinical Network so this could be shared more widely via the web.

Group 1 notes

- Need a clear definition of public health.
- Core functions comments:
    - Very 'disease' focused
    - Doesn't 'relate' well to what NGOs actually do.
    - What happens to the 13 different areas of work?
    - Can be controlled by public health specialist for this 'priority'.
    - Need to promote integration of health with other sectors.
    - Risk DHBs will mainly contract with themselves or PHOs.
- Service components need further description to be more encompassing and integrated, and encourage working across service components.
- Specifications should be about quality, contract about quantity.
- How can purchasing models incentivise integration? Funding partnerships?
- Does core function description encourage fragmentation of expertise?
- Put core function table under 'service definition' section.
- To achieve integration, we need 'joined up' thinking from the MoH.
- In order to achieve good public health outcomes, the MoH needs to have a strong policy unit/programme to provide direction and leadership. Stop restructuring MoH!
- Stable long term environment – set specification well and stick with it.
- Accountability framework as a funder.
- Public health providers have to be accountable.
- Need to articulate outputs/outcomes.
- MoH needs to contract outputs and outcomes.
- Core functions model puts specific service components at risk – if you aren't included as sector, you aren't included. Need protection for the 13 issues.
- KPIs for each service component.

Group 2 notes

- Thank you for engaging with us.
- Need a framework that captures what is happening in the health sector.
- What are the criteria for framework?
- What are the advantages/disadvantages?
- Context
    - Kia Tutahi Accord
    - WHO – Ottawa Charter
    - Whānau Ora
- Conversations pathway
    - Providers
    - Target audiences
- Short and long term implications for providers/target audiences.
- What is the process for establishing the new criteria?
    - Best practise – success?
    - By experts?
    - Compatibility to wider government but not tied to govt.

NGO Attendees

Amanda Reid	Kapiti Choices Inc
Bruce Bassett	Quit Group
Jack Schierhout	Quit Group
Jackie Edmond	Family Planning Assn
Joe Asghar	Diabetes NZ
Joyce-Anne Raihania	Injury Prevention Assn of Aotearoa NZ
Keriata Stuart	Public Health Association
Marge Jackson	Kites Trust
Marilyn Head	NZ Nurses Organisation
Peter Gladstone	Kapiti Crossroads Trust

Notes from Dunedin Public Health Engagement Workshop to discuss Tier 1 Service Specification – 5 July 2012

Key points from report back and general discussion

- Public health providers keen for more integration with the rest of the health sector.
- What are the measurable things about public health that we SHOULD be measuring?
- Need more upfront about populations – recognise different determinants of health across population groups and that people respond differently to different approaches.
- Should other population groups be noted in the specifications? Only children/Well Child identified currently.
- Is ageing a new public health issue to specify? (Most people over 75 years have 3 chronic health conditions.)
- Need an emphasis on Māori to raise their health outcomes/life expectancy to the level of the rest of the population.
- How do health promoters link people to services? NGOs need to have a health promotion arm too or better links with DHB health promoters.
- Need to ensure that national health promotion strategies fit with local strategies (consistent messaging, etc), i.e. service linkages section needs to be clearer and provide direction.
- Integration occurs through collaboration.
- The current wording is right in places but the implementation is not always happening as specified, e.g. NGO section page 9 – wording is good but reality not measuring up.
- Short concise documents are good.
- Onus on government to show the impact of spending – needs to get better at collating data to show health outcomes.
- Meaningful reporting, that is not onerous, is important.
- Current service components are so specific that they don't allow providers to respond to opportunities – limiting.
- Public health's lack of integration is an issue.
- Need to identify short term and intermediate outcomes.
- Change to 3 overarching themes: protection, partnership and participation.
- A core functions approach has the potential to increase collaboration and potential to be more engaged and respond to opportunities, however things may be lost if key service components not listed. Perhaps key areas could be listed under the functions like in the Canada model.
- How will funding priorities be managed under a functions approach? How will they link together.
- Will one person within MoH be dealing with all contracts of a certain type under the functions approach? Likely to become hard to contact and not have good understanding of portfolio as many do now.
- We want specifications to identify specific things like child protection, mental health, etc.
- Specifications should be reviewed again in three years time.

- The devil is in the detail. What would a contract look like under the new Tier 1 specification? (esp. if a core functions approach taken). Perhaps model a typical contract as part of the consultation document.

Group 1 notes

Thoughts on current spex:

- Limited/specific in services – does not allow for other scope of your services. (Very few target groups have only one issue.)
- Consultation: How to spread the 'Health Promotion' way? What is it? How is it?
- Public health lack of linking with other services/community.
- Outcomes are long term without clear connection to immediate intervention.
- Need improved accountability of services/PH funding.

What we like:

- Like population focus (different populations respond/reflect health issues differently, e.g. Māori).

Suggestions to improve:

- Have three overarching themes:
    - Protection
        - Assessment
        - Status
        - Surveillance
        - Disease distribution
        - Public hazards
    - Partnership
        - Capacity development
        - Services
        - Social environment
    - Participation
        - Health promotion
        - Health literature
        - Preventative intervention.

Group 2 notes

- Generally support the 5 core functions approach as it provides a more comprehensive view of public health.
- But concerned about the potential loss of MoH portfolio managers and the loss of historical knowledge.
- Pluses of the core functions approach:
    - More 'engaged', 'active' = increasing well being, outcome focus
    - Extend current roles and services
    - Increased collaboration.

- Minuses of core functions approach:
    - Potential loss of services (e.g. small specific service) – want sub genres
    - Changes in funding priorities
    - Recognise benefit of dealing directly with MoH – one contract managers for all programmes. Portfolio managers – family groupings.
- Needs to get reviewed within 3 years (page 6).
- Identify specific things, e.g. child protection, mental health.
- What we'd change/improve:
    - Make sure a broader ethnic mix is included
    - Make sure ageing population is included
    - Smaller, shorter, more concise.
- The devil is in the detail!

NGO Attendees

Chris Maxwell	Te Roopu Tautoko Ki Te Tonga Inc.
Donna Mataheare-Atariki	Arai Te Uru Whare Hauora Ltd
Gareth McMillan	Theatre in Health Education Trust (THETA)
Henry Mbambo	Presbyterian Support Otago
Jan Christie	OPEN consumer group – Otago Partners for Elder Needs
Niall Shepherd QSM	Age Concern Otago Inc.
Odele Stehlin	Waihopai marae-based services
Patricia Appleby	OPEN – Otago Partners for Elder Needs & Christian Fellowship for Health
Philomena Shelford	Waihopai marae-based services
Reuben Moses	Te Roopu Tautoko Ki Te Tonga Inc.
Sallyjane Cranfield	Disability Information Service
Susan Davidson	Age Concern Otago Inc.

Notes from Christchurch Public Health Engagement Workshop to discuss Tier 1 Service Specification – 12 July 2012

Key points from discussion and report back

- Need an overarching public health statement.
- Public health is about people acting in their best interest where they are not currently.
- Have a high level discussion about principles.
- MoH needs some guiding principles agreed with NGOs around responsibility/integrity to safeguard against the 'next big thing' from overseas coming in and taking us off track.
- Include guidance for MoH employees to give them an understanding about NGOs and the history, relationship, etc and how to work with them. NGOs often feel like they have to 'induct' new MoH staff when they interact with them – give them more guidance as part of MoH staff induction.
- Detail in the service linkages section of the Tier 1 is not translated through into contracts – needs a big rehash.
- Incentivise collaboration.
- What will the long term implications of changing be?
- The 2nd box on the core functions slide *'Health improvement and disease and injury prevention'* is huge as it encompasses all the social determinants of health as part of the environmental and societal drivers of health across primary and secondary services – virtually the whole health budget!
- What's best practice in terms of procurement?
- DHBs need to be transparent about what they fund – especially if contracting to their own provider arm. NGOs willing to share what they are contracted to provide but need to know what PHO, DHB and public health units are required to deliver so NGOs can see how they can complement each others' services and work together.
- Fewer RFPs and a less competitive model of funding would be good – get the NGOs round the table and ask them what bits they can deliver – many NGOs know their strengths and are willing to collaborate.
- Political neutrality clauses are too tight/restrictive.
    - Advocacy and lobbying is a core function of many NGOs.
    - Govt departments are 'political' because they serve the Ministers of the day, who are working along party lines.
    - Recognise that politicians only make change when they believe voters want it (i.e. they have the support of the people.) The population learns of issues and gets keen for action based on advocacy, evidence and communities lobbying for change, i.e. without some advocacy nothing would ever get done – we need NGOs to speak up on issues.

- Look at how MoH/govt should support lobby groups – room for conversations around this – the current hands off approach can mean small interest groups can wield excessive influence/power, whereas supporting others could make it easier for govt to hear the views of the 'hard to reach'.
- Current tight clauses make it impossible for an NGO to publicly support an issue like longer parental leave, because a political party is supporting it.

- What impact will the current govt's 10 health priorities have on the 13 service lines and funding prioritisation? The current 13 service components were priorities for the government of the time – the service specifications need to be less 'political'.
- Need to consider resources to help workforce development, change of practice, etc.
- Not sure we like much about the current spex.
- It would be useful to align Tier 1 with an overarching public health statement and not split it up over different bits.
- Should legislation be included in Tier 1 at all? Most only relevant to some. Maybe put it in the relevant Tier 2.
- MoH needs high level visions for the health of the population that don't change when government changes.
  - Could be based on UN declarations/conventions that our governments (past and present) have signed up to (but then become less visible).
  - These are 'big things' that we should all care about and that could provide a stronger framework for action.
  - Objectives need to transcend political party changes – specifics should fall out of the bigger picture.
  - Current Ministers' priorities should then fit under these.
- A need for local (i.e. NZ) research – independent, comprehensive.
  - Don't always give priority to overseas international research with larger cohorts – recognise that NZ research on Maori and Pacific people will often be dealing with small numbers – but still has value and more relevance for our populations.
  - If international research is used – contextualise it for NZ.
  - Support local research and share what research is done here more widely as it is more relevant.
    Useful link: www.communityresearch.org.nz/
  - Ethnicity data capture should be mandatory – esp. for Maori and Pacific.
- We need equity of health outcomes.
- Be realistic about expected outcomes and measure what counts.
  - It's hard to track a direct outcome and info gets 'lost' because it is dealt with in isolation.

- This contributes to 'woolly' perception of public health because many different actions contribute to whether someone makes a behaviour change/takes action and not easy to measure how a specific action influenced their behaviour.
- Attributability is hard, but better evaluation and measures would help.
- NGOs/providers not in best position to do this – MoH needs to get better at this and share the results – not expect NGOs to divert the funds allocated to deliver services to do evaluation (e.g. one provider expected to use funds provided for TV advertising to do evaluation instead, i.e. had to reduce advertising.)
- MoH needs to do nationwide evaluation, rather than always expect individual services to evaluate – this would give government a better picture of the combined value it is getting from its investment in a range of public health services.
- Example given of Victoria Cancer Council, which monitors changes in beliefs/attitudes and combines it with treatment data and reports along the lines of "the sum total of the effort is producing this….". This recognises that you don't get the action change until you have the belief.
- Some contracts based on faulty assumptions and no mechanism to address this.
- MoH needs to get more engaged with sector on measuring outcomes – policy is quite removed from sector.
- Poor measurement in some cases where data is not collected – e.g. with infants' hospital admissions, not asked 'how is this child being fed?' – which could help to show how breastfeeding avoids hospital admissions.
- Targets can drive some perverse behaviour (creating a tick box approach.)
- Recognise that public health services need different measures for information provision/health promotion and intervention/treatments. Easier to contract for x number of immunisations etc, whereas not as valuable to contract for x number of brochures distributed etc.
- Align measures with MSD and other agencies addressing health determinants and track these based on NHI numbers – get come consistency about how and what info is collected so that local providers can feed their data into a national collection.

Group 1 notes

- Ministry employee guiding document to support how they engage with each NGO/ contract holder – expectations on how they engage.
- Minimum body of knowledge for each portfolio manager:
    - Nature of contract
    - Nature of NGO – kaupapa
    - Historic context of contract and NGO.
- Guiding principles that NGO and Ministry agree to in the document – intent.
    - Responsibilities, integrity – to safeguard being taken off track.

- Clear on areas for reporting. Does not change within contract period without joint korero and agreement.
- What impact will the government's 10 health priorities have on the 13 lines?
    - Anxiety around what services and NGOs may be lost to ensure delivery of government's 10 priorities.
- Health equity (Maori)
    - Research kaupapa Maori services to support the model of working with whanau, rather than taking on the next big thing from overseas.
- Ethnicity data capture should be mandatory for all.
- Environment is not set up to support the sharing of info/models between providers to enable best delivery to Maori whanau.
- MoH should have a directory to assist communication and access.
- Reporting – becoming more onerous (quarterly, monthly, six monthly…..)
    - Spend more time talking/reporting about what you're doing.
    - No dedicated funding to support extra reporting requirements.
    - Appears not purposeful.
    - Individual portfolio manager requires specific reporting – valuable $ spent to produce report opposed to spending $ on enrolling clients.
- MoH should contact and discuss likely reporting changes in new contract period.
    - Negotiation period for new contract should be mandatory.
    - All templates should be delivered at same time as contract discussed.
    - Extra reporting has req – extra time/$. Require outside consultants to assist staff.

Group 2 notes

Current approach

- Not clear which category individual services fit within.
- Question focus on clinical service model – not public health model.
- Encourages silo thinking.

We like

- Headings and format – logical flow.

Change/improve

- Don't split service delivery contracts over many portfolios.
- Overarching public health statement of intent rather than 13 categories.
- Transparency.
- Workforce development.
- Improved communication.
- Be realistic about advocacy and political neutrality – needs clarification.
- Principles of relationship contractor/provider (relationships, role, reporting, etc).
- Best practice in terms of procurement.
- Integration between MSD & MoH.

- Question as to where legislation fits – should it be in Tier 1 at all?

Group 3 notes

- Targets drive perverse behaviour.
- Enable collaboration between providers centred on individuals' needs – monitor by NUI?
- Alliance contracting – incentivise collaboration.
- Realistic expectations of outcomes – achievable.
- Differentiation between broader public health objectives/values/vision and treatment interventions e.g. smoking cessation.
- Improved and more sophisticated monitoring and evaluation of public health programmes – managed and funded nationally, e.g. attitudes and values, belief in messages.
- Public health gateway to interventions.
- Expect more than one provider may need to be involved to gain desired outcome.
- Objectives need to transcend political imperatives and priorities.
- Political neutrality – providers need ability to advocate for evidence and populations they work with, within contract resources.
- Advocacy/lobbying is a core function of NGOs – many NGOs grew out of advocacy groups.
- Public health intelligence – national.
- Too much service specific detail – should not be in Tier 1 specification.

'Parked' issues

A range of topics of concern arose during the discussions and the MoH staff and NGO Working Group undertook to take them back and share them and work to address them where this was within their ability. These included:

1. Communication
    - Mixed messages from MoH
    - Confusion about MoH structures, staff changes and key contacts.
    - Nice to know who your contract manager is – need a process for when people leave/change.
    - Need a MoH directory to help with communication and contact – don't know who does what or how to reach people.
    - Not good processes with telephones – people can be away and not leave a phone message about who to contact in their absence and no-one else in MoH seems to know – get passed around.
2. Contract discussions
    - Often conducted in a disrespectful manner where MoH/DHB wields power over NGO – not a partnership approach that shares accountability.

- DHBs not passing on cost of living increases to NGOs, whereas direct contracts with MoH usually do. DHBs absorb the extra allocated funded for themselves
- Confusion around contracts and current different consultations
  – what is the hierarchy, timing of changes taking effect, what influences what, how do they all fit together e.g. header agreement templates, Tier 1 spex, service schedules, quality spex?
  – MoH needs to explain better and be clear about what is negotiable for an individual provider.
- In response to positive comments from MoH staff present, NGOs said it was good to hear that the MoH wants to be more engaged, but that many of the MoH staff they have day-to-day contact with don't know what is going on elsewhere in the Ministry. (The Piri Weepu tv ad controversy was given as an example where two different parts of the Ministry knew what was going on and supported it, but there wasn't the bigger picture view that recognised the conflicting messages.)
- Some NGOs thought in instances where the Ministry had funded a provider, programme or service, and that in the main delivery was of a high standard, the Ministry should be more vocal and upfront in its support and not leave it to providers to front on issues or take all the flak (e.g. midwifery).
- When things do go wrong – be willing to have the conversations about what we can learn.

3. Reporting requirements
   - Onerous extra reporting, often ad hoc in addition to that specified in contracts, time consuming, often unreasonable timeframes (e.g. today, this week, now.)
   - Impacts on NGOs ability to deliver services.
   - Ad hoc 'over-reporting' takes resources away from service delivery – can come out of the blue without any discussion and with unrealistic timeframes – especially difficult for NGOs that have Boards and own reporting processes to manage.
   - MoH staff present said it was not correct to say you can't vary a contract during a contract term and that providers should be able to re-negotiate terms if additional reporting were asked for after a contract signed. NGOs said this was not the impression they got and that they were often told "I need it now" or "you need to report to me on this". If they questioned this, some contract managers would have a take it or leave it approach and use their 'power' to say things such as "so would you not deliver?" The nature of the dialogue gave the clear impression that the NGO had no choice.
   - Some NGOs wondered if this 'power' imbalance and lack of respect varied according to the size of the NGO and whether there were multiple providers.
   - Different expectations around reporting – sometimes different DHBs ask for different stuff (want split or merged info) – not notified upfront – can be onerous.

- Hard to see the connection between providing info and delivery of services (e.g. NGO reports that they provided info to encourage immunisations or smoking cessation – but MoH systems don't make connections to whether child actually immunised or smoking treatment sought as this is often delivered by a different provider.)
- Process not clear about why certain information is reported – MoH/DHBs need to get better at explaining why certain info is required.

4. Impact of IT
    - Some NGOs will need help to upgrade as technology changes ever more rapidly.
    - The costs of this are likely to be more than what can reasonably be covered in current funding formulas that expect NGOs to absorb many of the costs of running the business.
5. Isolation of providers
    - Government keeps asking providers to work together and in some case developing integrated contracts – would be good to hear from MoH, MSD, etc about how the govt agencies are integrating what they do and how they work.

NGO Attendees

Alison Eddy	NZCOM - NZ College of Midwives
Barb Long	Royal NZ Plunket Society of NZ
Janine Pinkham	La Leche League NZ
Jo Houston	Smokechange
Julie Stufkens	NZ Breastfeeding Authority
Karaitiana Tickell	Purapura Whetu Trust
Katrina Hogg	Smokechange
Paula Snowden	Quit Group
Robyn Wallace	He Oranga Pounamu
Suzi Clarke	Te Puawai Tanga

Additional comments/suggestions received electronically

A few people joined the online discussion space on Facebook, but no real discussion eventuated. However, some people did e-mail suggestions and comments, and these are included below.

- As a service-user-led mental-health promotion NGO, we are hoping to encourage you to extend your invitation to people who use public health services and/or conduct a consultation series specifically with groups of service-users. We feel strongly that any changes to the way in which services are offered in NZ need to be informed by those who use them. Changes that affect service-providers, inevitably affect service-users.

  One way in which you could link with mental-health service-users (who are also high users of other public health services): There are a range of consumer and service-user networks, which it would be good to see [you] consulting with. In Auckland, the Regional Consumer Network hosts monthly forums with high participation that you could link with. I have CCed Tina Helm, the manager of Regional Consumer Network, into this email, in the hope that this will facilitate a consultative partnership with those who use the services likely to be affected by any changes.

- I think there is untapped potential in this service component (P.5 of SPEX): "Social environments including healthy cities and communities, health promoting schools." I remember Louise Croot – one of the great health promoters (now retired) used to do excellent work in Otago under this area, i.e. whole social environmental portfolio allowed work to be done across settings – working with TLAs etc., allowing for high level cross sectoral work.

- My reflection of the current state of PH Service Specs is that they ironically can and do create silos (I say this is ironic because PH/health promotion (HP) is a de-silo-ing activity at best). So when working with communities, ideally HPers are needs led not service spec's led – so for instance having to work on smokefree issues rather than what the community might want to attend to, like violence prevention or mental health concerns.

  Secondly, the service specs do need updating regarding emerging issues such as the 'aging and browning' of NZ societies – therefore HP for the elderly is almost non-existent (some things exist like fall prevention).

  The evaluation issue is paramount – this needs work regarding what and how evaluation happens. What gets measured? The need for and use of mixed methods is critically important; and the development of an evaluation plan right from the beginning of programmes – no evaluation plan, no funding. A small example is the outcome focus – just what this means? Whakawhanaunatanga connecting with people to develop relationships and therefore meaningful and sustainable partnerships is important for HP processes and needs to be understood in evaluation planning.

  This is an important project – policy precedes practice – and this is particularly true for PH – look forward to the consultation document.

- Excerpt from *NZ Sexual Health Society Submission to the Ministry of Health Regarding Review of Sexual Health Service Specifications (March 2012)*

LACK OF INTEGRATION OF REGIONAL PUBLIC HEALTH SERVICES WITH SEXUAL HEALTH SERVICES

Sexually transmitted infections can cause significant morbidity with some sectors of the community more at risk including young people, men who have sex with men, those of Maori and Pacific ethnicity. Despite this no monitoring or evaluation of current STI surveillance trends are occurring. Regional public health services need to be actively involved in monitoring trends in STI prevalence and incidence and respond appropriately in co-ordination with regional sexual health services. Unfortunately there is currently no specific mention of the need to address STIs in either the communicable disease services specifications or the public health services specifications and these omissions need to be rectified.

Sexually transmitted infections need to be specifically included under communicable diseases as a core responsibility of public health services.

The documents refer to the now outdated health act of 1956. The urgent enactment of the public health bill is required so that we have a modern approach to the management of communicable diseases. This needs to be urgently placed on the government's legislative agenda.

- For example, the deficiencies of the current 1956 Health Act are evident as important communicable diseases such as syphilis and HIV are not currently notifiable and could pose a significant threat to public safety. No formal public health response has yet to be established to investigate the increased incidence and prevent further transmission of infectious syphilis.
- The 1956 Health Act also refers to the responsibilities of medical practitioners treating people with "venereal disease" and responsibilities of individuals infected with "venereal disease" (in sections 88, 89 and 92) however there is no specific provision in the act allowing for publically funded treatment of STIs in individuals who are not eligible as there is for other communicable diseases such as tuberculosis. We recommend that otherwise non-eligible people suspected of having a bacterial sexually transmitted infection and who may be infectious should be eligible for free screening and treatment at specialist sexual health services to prevent further disease transmission.

The public health specifications state: "Develop or review and revise contingency plan(s) providing for response monitoring, incident investigation, public communication and follow-up for responding effectively to public health emergencies, emergent issues and communicable diseases outbreaks." This is not happening for STIs.

For example despite the world-wide trend of increasing gonorrhoea anti-microbial resistance, New Zealand has taken no action regarding current regional epidemics of gonorrhoea.

Public health services need to monitor regional and national STI surveillance trends in ESR data and to take appropriate action on emerging adverse trends. NZSHS recommends an annual meeting of sector experts to discuss trends in STI surveillance and what action is required.

Summary

The lack of any formal connection of regional sexual health services to regional public health services has resulted in: A lack of resources for specialised contact tracing, no public health input to STI surveillance, no ability to respond to disease outbreaks, a lack of co-ordinated health promotion strategies to reduce STI prevalence and incidence and a separation of clinical services and health promotion in most centres.

NZSHS recommends formal integration of regional public and communicable disease services with regional sexual health services so that a co-ordinated approach to STI control can be implemented.

NZSHS recommends an annual meeting of sector experts to discuss trends in STI surveillance and what action is required.

Electronic contributors

- Miriam Larsen-Barr, Service Director, Engage Aotearoa
- Richard Egan *PhD*, Research Fellow/Teaching Fellow, Cancer Society Social & Behavioural Research Unit, Te Hunga Rangahau Ārai Mate Pukupuku, Department of Preventive & Social Medicine, University of Otago Medical School, Dunedin
- Sunita Azariah, President, NZ Sexual Health Society

Ministry of Health/DHB staff present at one or more workshops

Roz Sorensen – Facilitator
Kathrine Clarke – Presenter
Jo Elvidge
Warren Lindberg
Andrew Forsyth
Sene Kerisiano
Peter Burt

Donovan Clarke – Southern DHB

The Health and Disability NGO Working Group looks forward to seeing the views of the non-profit sector reflected in the consultation document released later in the year.

Notes compiled by

Grant Aldridge, Secretariat, NGO Working Group
secretariat@ngo.health.govt.nz
www.ngo.health.govt.nz