Healing the Breach: Can a Government Health Board Rebuild Community Trust?

Glensor P*

Hutt Valley District Health Board, New Zealand

Abstract

In New Zealand from 2000, 21 District Health Boards (DHBs) were established after a decade of a commercialised corporate model of health planning and provision. DHBs are charged with implementing the government's health policies, funding and providing health services, and improving the health status of their population. With a mix of elected and appointed members, they are accountable both to their community and to the minister.

This presentation describes how Hutt Valley DHB has worked to set up processes so its community of 135,000 can be a genuine participant in the DHB policy development. The DHB's Strategic Plan drew in hundreds of provider and community participants. Extensive public and interest group meetings ensured the new Primary Health Organisations were truly community-based, not just 'GP associations in drag'. Health plans for Maori and Pacific communities were strongly community-driven. The policy of inclusion and engagement is being developed within the DHB's own services, especially through involvement of clinical staff in service development. Community engagement requires constant commitment, as community trust can easily be lost.

Keywords

Health board, community engagement, strategic planning, consultation, New Zealand

Ka nui nga mihi ki a koutou katoa kua tae mai i tenei wananga. Ki nga tangata whenua o tenei takiwa, ki nga rangatira, nga kaiwhakahaere, ki a koutou katoa — tena ra koutou katoa.

Formation of District Health Boards in New Zealand

During the height of the neo-liberal excesses of the 1990s, public hospitals were renamed Crown Health Enterprises (CHEs). The 23 CHEs that were established were to adopt a company structure and were expected to operate as commercial enterprises. Later in the 1990s, the government, realising that the model was not working, removed the requirement to make a profit, and urged the CHEs to collaborate more with one another. The boards of directors of these CHEs were appointed by the minister of health, with most of the directors coming from commercial or legal backgrounds. In the late 1990s, the minister of health began seeking nominations from local authorities for new directors. The name of the entities was changed to Hospital and Health Services (HHSs). By and large, the boards were anonymous to the general public and there was widespread suspicion of the corporate model.

In 1999 a Labour-led coalition government came into power, with an explicit promise to disband the HHSs in favour of publicly elected district health boards (DHBs).

Having published a new health strategy, the minister began the process of setting up the DHBs.

There was a strong emphasis on ensuring there was no disruption to current services and on maintaining public confidence in public health and disability services. At the same time, there were significant differences from the previous health regime. For the first time ever, almost all the health funding for a specific region was being held in one 'pot' — the DHB. DHBs were to focus on health gain and independence among the population they served. They would be expected to work within allocated resources to raise the overall health status of, and to reduce disparities in health status within, their population. They were to focus on cooperative relationships at the local level, establishing partnerships with service providers and to engage communities, including tangata whenua[1] to build effective local 'health communities'. They were expected to maintain an underlying level of consistency overlaid with responsiveness to local/regional/national needs and preferences. This would involve including local communities in resource allocation, ensuring that local communities are aware of resource constraints, and building recognition and ownership of prioritisation decisions made on their behalf. In particular, DHBs were to support participation by Maori. Both as a reflection of their commitments under the Treaty of Waitangi[2] and in order to achieve health gain for Maori, DHBs will support Maori to participate at all levels in their areas, actively support Maori provider development and ensure all services are delivered in ways that are effective for Maori.

Transitional DHB Board members were appointed in August 2000, with elections held as part of the local council elections in October 2001.

While they have a majority of locally elected members, they are kept strongly within the government's control — their income is provided from Vote: Health. Four of their 11 members are appointed by the government, as is their chair and deputy chair. Their key task is to implement government policy, even while they seek local solutions to local problems.

They are a fascinating new star in the governmental arena — part government department, part local authority and part commercial enterprise. Both a funder and a provider, and accountable both to their community and to the minister.

In the 2000 legislation setting up DHBs,[3] their role was defined as:

- to improve, promote and protect the health of communities
- to reduce health disparities by improving health outcomes for Maori and other population groups
- to reduce health outcome disparities

[1] The Indigenous, first nations, Maori — it literally means 'people land' and is variously translated at 'the people who are the land' or 'the people of the land'.
[2] Signed in 1840 by representatives of the British Crown, and eventually 512 Maori leaders — it was the basis of the assumption of governance over New Zealand by the British.
[3] *New Zealand Public Health and Disability Act 2000*.

- to foster community participation in health improvement, in planning for and changes to the provision of health services
- the integration of health services
- effective care
- the inclusion and participation in society, and independence of people with disabilities
- to uphold ethical and quality standards
- to exhibit a sense of social and environmental responsibility, and be good employers.

I came into this role with two backgrounds. I had served a three-year term as a city councillor. I watched how 'public consultation' processes were both used and abused. From time to time, our local council would set up excellent processes, laying out options, and providing time and space for the community to give feedback. More often, they provided a pre-determined option, with processes that ensured the preferred option would be followed.

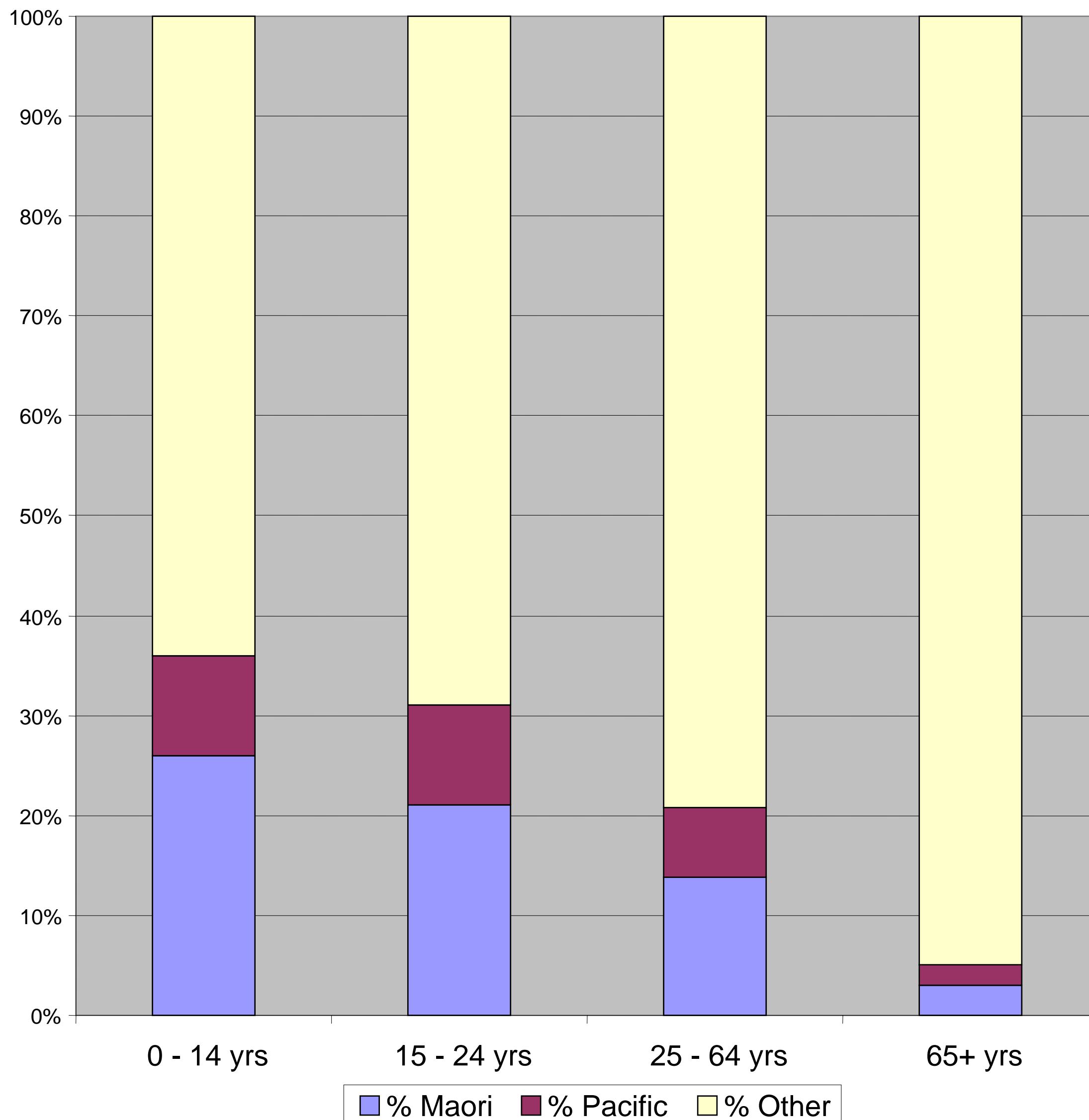
Most of my own adult life has been spent within the community or NGO sector. From that perspective I have been subject to years of 'consultation' from local and central government. These often negative experiences meant that the obligation on us as a DHB to "foster community participation in health improvement, in planning for and changes to the provision of health services" was a high priority.

Hutt Valley District Health Board

With a population of 138,000 the Hutt Valley DHB has a population profile not too different from the total New Zealand population — by ethnicity, and by socio-economic status (Table 1). As the Act requires, the Indigenous Maori population and the migrant Pacific population are priorities groupings for our DHB and for social policy planners generally. They are younger and poorer than the general population. Their numbers and their proportion fix of the general population are predicted to grow. Their health status is markedly worse than the general population. All DHBs are charged in legislation with reducing health disparities of these two groups, through working with their communities to improve their health outcomes.

One difference for us, compared with the New Zealand averages, is that we have a higher than average proportion of people in the least deprived quintile. There are distinct neighbourhoods which are very affluent, and others which are very poor. This has an impact both on how we communicate with the various parts of our community, and how we plan the provision of health services. Because of our focus on health needs, our priority must be on particular neighbourhoods while maintaining a concern for the whole of our population.

Table 1. HVDHB population 2005



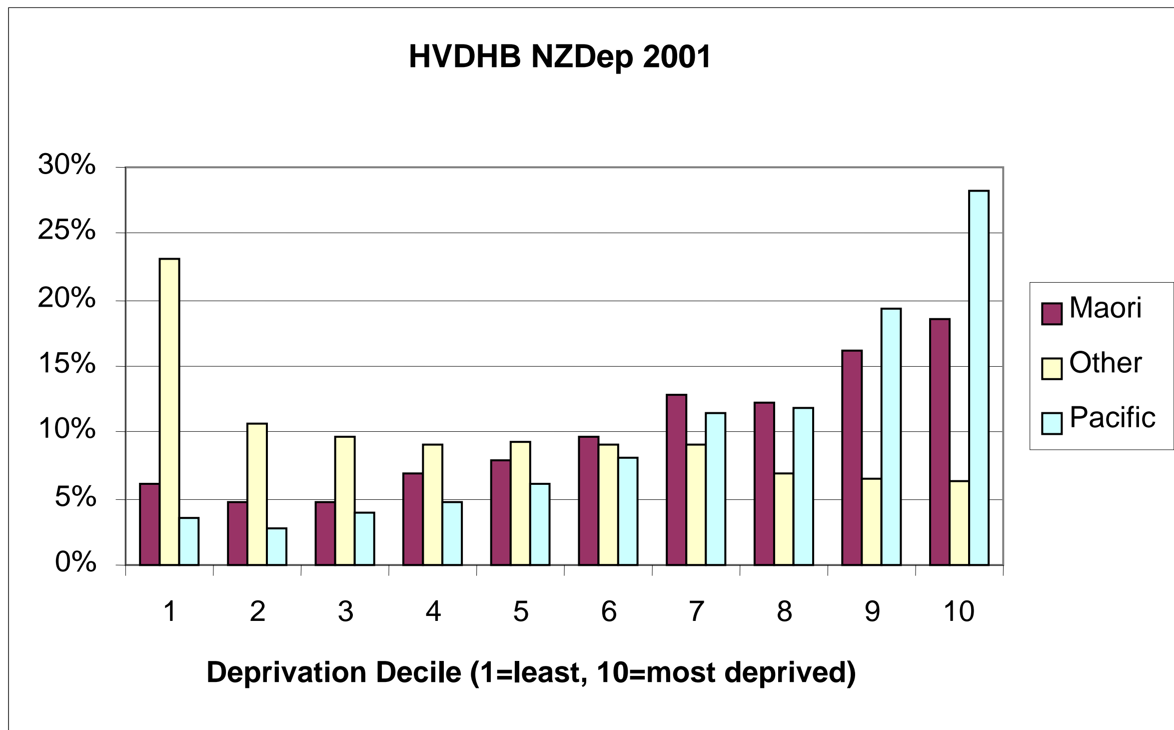
We are fortunate that our DHB population is within a relatively small area. We have two cities — one of 100,000 and one of 40,000. There is almost no rural component to our district, and we have only one public hospital — part of the DHB's 'provider arm'. The other feature of our DHB is that we host a public health unit, which serves two neighbouring DHBs as well as ours. This gives us a superb chance to make use of the public health intelligence and services.

We have an operating budget of around $260 million and for the past two years, unlike most other DHBs, have been able to operate with a small operating surplus. News media coverage of our DHB is positive and we are not beset by the negative news coverage that plagues other DHBs. By and large, our capital plant and buildings are in good repair even though we are currently planning over $12 million of capital works to improve the hospital campus. There is an

intense feeling of loyalty to and 'ownership' of our public hospital, which translates into a positive perception of our DHB.

All these features mean we are extremely well placed as a district health board.

Table 2. HVDHB deprivation deciles, 2001



District Strategic Plan

Our first real community engagement was to prepare a 5 to 10-year District Strategic Plan. We wanted this to engage our community, while meeting the voluminous requirements placed on us by the ministry of health. (Personally I fully support the fact that our tiny country should have one, not 21, health programs and systems, but we are still working through the practicalities of how the 21 DHBs can operate in response to local situations while operating within a cohesive national framework.)

We opted for setting up seven service planning groups:

1. Healthy Communities
2. Chronic Diseases
3. Youth
4. Child and Family
5. Mental Health
6. Primary Care
7. Disability Support.

For each of these, we sought people from our own staff, local providers, NGOs and the wider community. Finally, around 120 people were engaged — working under tight schedules, with many hours of work within each group. The groups were asked to cover:

1. What is currently the situation in that area of work?
2. What is your vision of what could be done?
3. Are there any areas of work the DHB should consider reducing or cutting
4. If we had additional funding, what are some key new initiatives we could develop?

It was this last question that captured the imagination of the working groups. At the end of the service planning process the HVDHB had some 40 proposed initiatives at a total cost of some $8 million (c.f. an annual budget at the time of some $140 million). They also had four savings proposals with a maximum value of $1 million. The board was aware that some additional funding could be expected over the next five years, but did not expect that funding would be sufficient to cover all (or even most) initiatives. They asked officers to develop a method by which the proposals could be ranked using the decision-making principles previously adopted by the board.

The board then debated whether it was falsely raising expectations to include in its draft plan a list of possible initiatives. We decided that we would take a risk and include the whole list of possible initiatives, and would also include the methodology used to rank the projects in priority order. The weightings used were strongly debated, and changed, so that the balance in particular between 'value for money' and issues of equity reflected the board's priorities.

The second area where we departed from a 'safe' approach was to declare a priority among the ten key areas for the DHB over the following five to ten years. The list was carefully worded to ensure that all part of the health system could be included — old and young, prevention and cure, acute and elective needs, mental and physical health, etc.

The ten key areas were:

1. Primary care
2. Healthy communities
3. Reduce inequalities
4. Disease management
5. Elective services
6. Child health
7. Youth health
8. Maori health development
9. Mental health
10. Integration.

We agreed to include in the plan the following:

> Over and above maintaining access to core services, the Board considers that the single highest priority for the next five years is implementing the primary care strategy. The reasons are:
>
> 1. Development of excellent primary care services will make the single largest difference to people's health in the short to medium term;
>
> 2. The primary care strategy is pivotal to achieving most of the other key goals.

The draft District Strategic Plan finally included a list of 44 possible new projects and our declaration about priorities. Summaries of the plan were published in our local papers and the normal round of consultation was held.

I note two specific areas of interest for this conference.

Firstly, the public response was very strongly positive. People generally were in strong support of the proposed strategies, and the proposed initiatives. I had feared that our emphasis on community and primary health would be challenged by people more concerned to protect our hospital. We also wondered if people would challenge the proposed initiatives. Neither of those things happened.

Secondly, after two years we found that almost all of the initiatives (which had, by this time, grown to around 60) had been fully or partly funded. The risks we took had proven worthwhile.

Primary Health Organisation development

Shortly after their election in 1999, the government introduced a Primary Health Strategy. The strategy's reforms are progressive and far-reaching and strongly grounded in broader notions of primary health care. The strategy's objectives are listed below.

Table 3. Aims of the New Zealand Primary Health Care Strategy

- Better health for all
- Reduced health inequalities
- More emphasis on population health
- Better access to primary health care services
- Coordination, continuity, collaboration
- Community participation
- Primary health care fully involved in health system.

A particular feature is the focus on health disparities, driven by realities such as the large gap between Maori and non-Maori mortality rates.

The main instrument of implementing the strategy is Primary Health Organisations (PHOs). These are defined in the Primary Health Care Strategy as "Local provider organisations funded by a DHB to provide a specified set of essential primary health care services to an enrolled population."

PHOs were, like DHBs themselves, developments of earlier initiatives with some specific 'twists' by the government. The major primary health groupings at this time were Independent Practitioner Associations (IPAs). They were groups of general practitioners (GPs). Some were companies, some were non-profit bodies, but they were almost all made up only the for-profit GPs. The government outlined eight minimum requirements for PHOs:

Table 4. Primary Health Organisation (PHO) — minimum requirements

1. Improve, maintain, restore health — service specifications
2. Work with groups with poor health to address needs
3. Coordinate care with other providers
4. Enrolment
5. Communities, iwi, consumers involved in governing processes
6. All providers/practitioners can influence decision-making
7. Not-for-profit, full and open accountability
8. Capitation funding formula.

There were a number of key differences in this list from the status quo in the primary health sector.

There was an explicit focus on improving the health outcomes of high-needs populations. The PHOs were to include a range of providers and no single group could dominate the decision-making processes. The community, iwi[4] and consumers were to be participants in governance.

[4] Maori term for the nation, the people or the tribe.

In some parts of the country, existing IPAs simply reformed themselves into PHOs, and were approved by their local DHB. Our DHB was determined that the roll-out of PHOs in the Hutt Valley would be driven by a genuine community engagement. Early on, we approved the establishment of a small PHO — bringing together some practices and providers who already had a strong community base and who were serving a very high needs community.

We then began dialogue about how the bulk of our population could benefit from the considerable amounts of new government funding being made available to PHOs. The local GPs, mostly involved in one organisation, made it clear that they wanted to continue their current structure and form one large PHO for the whole Hutt Valley.

We decided that rather than ask the GPs to lead the community engagement, we would do so. We drew up a discussion paper about possible PHO groupings, including the GPs' preferred option. We then worked with our two city councils, and the mayors agreed to host public meetings where the whole idea of PHOs could be discussed.

We spent many evenings in meetings throughout our district, with hundreds of people learning about and discussing the Primary Health Strategy, what was meant by primary health care, how PHOs could work and what were their preferences.

It was apparent that the community people did not agree with the GP notion that one big PHO was the way ahead. At the same time, community people were hugely conscious that GPs are valued and essential players in the provision of primary health care. So, dialogue and compromise were needed. Under our active leadership, three community steering groups (CSGs) were set up in three parts of our district. Each had an open membership, and between 30 and 40 people took part in each group. There was a mix of community leaders, public and personal health agencies, GPs, nurses and individual community members. After several months of discussion, each CSG reported back to our DHB on their preferences for PHO establishment. What emerged was different to the options both we and the GPs had proposed. We have now ended up with six PHOs in our DHB area — probably too many for the size of our population. But they all exhibit a strong sense of community engagement. They vary hugely in size and in the visibility of GPs. One is explicitly a Maori-led PHO and two are funded differently because of the very high needs population they serve. Even as this paper is being prepared, there are shifts and changes taking place within them — with some providers wanting to change PHOs, and ongoing tensions in others between the community and the health professionals.

But we believe we have honoured the promise that PHOs would emerge from a process of community engagement and that they would be 'community driven'.

Other initiatives

In the past two years we have produced a number of plans. Three in particular were developed with extensive community engagement — Strategic Health Plans for Maori, for Pacific people and for Older Persons.

In each case, we held meetings with both provider and consumer groupings. Both the Maori and Pacific communities have strong and inter-connected networks, and we were able to draw on those networks for our work. The communities concerned are constantly being asked to comment on and be involved with the work of a wide range of local body and government agencies, so their willingness to be active participants in our planning processes was for us a vote of confidence that we would listen and respond positively to their input.

One of the striking features, particularly of the Maori Health Strategic Plan, was the considerable engagement we were able to have with 'mainstream' groups — our own hospital and health services, and community-based health providers. While there are a number of 'by Maori, for Maori' health providers, the majority of health service delivery to the majority of Maori people remains via the general health system. Any serious addressing of the current disparity of health outcomes must therefore address why the general health system is significantly less effective for Maori than for the general population. We believe this dialogue between Maori and non-Maori continues to be an important issue, and we believe our strategic plan processes have enhanced that dialogue. Many participants were energised by the engagement, and have signalled their desire for more — a hugely positive development for us.

For the Older Person's Plan, we worked in collaboration with our larger city council who were also working on an Older Person's Forum. We were concerned that the same people should not have to turn out twice for what was essentially a common purpose — what are the needs of elders in our community, and what kinds of resources and programs would help meet those needs.

The policy of inclusion and engagement is being developed within the DHB's own services, especially through involvement of clinical staff in service development. Our DHB has developed a culture of participation and collaboration, especially between clinical staff and management. There will always be a tension between health needs and available resources, and they exist also in our DHB. But we are constantly encouraging dialogue so that the proposed ways forward address both dimensions of our planning.

A regular meeting of clinical heads of departments, for example, includes as a matter of course:

- clinical nurse leaders
- service managers
- executive management team members
- representatives of general practice
- both the directors of medicine and of nursing.

We have recently set up a clinical board to offer clinical leadership in our DHB. So many staff were keen to be involved that a formal nomination, interview and appointment process needed to be held. The inaugural board has a good mix of most clinical professions covering the diversity of clinical services being offered in our DHB.

Reflections on community engagement

From this experience of leading a District Health Board, I have some thoughts about community engagement:

1. Community engagement requires constant commitment at all levels. Telling people what you have already decided is far easier to do than asking them their opinion in an open-ended way.
2. To ensure community engagement, we need to move beyond a minimalist way of working. We do all the things we are required to do — hold open meetings, publish our agendas and our meeting minutes, consult on service changes, etc. But we have sought to go beyond that — we have monthly 'community and provider forums' on a wide range of issues. Our staff and board members go out into their communities, seeking dialogue. We initiate meetings with our own staff, and with clinicians. We have a strong presence, both paid and 'free in our community newspapers. The result is that, while we are not markedly 'better' than others, we are applauded by locals and have a high reputation nationally. As our minister of health said in a recent local event, the Hutt Valley DHB embraces the opportunity to listen and respond to its community.
3. It is too easy to 'bureaucratise' what is essentially a human exercise — as an arm of government, our DHB has certain statutory and regulatory obligations, including the obligation to consult our community. Especially if people are not familiar with working with communities, the natural response is to look out a manual or checklist to work through. With the best of intentions, that can lead to a formalised 'non-engagement', which nevertheless fulfils the letter of the law.
4. There are skills in working well with communities. Those skills can be learned but are developed best in the doing.
5. When we take risks in the issues and questions we take to our community, we can be pleasantly surprised by the positive response we receive.

One of our staff, deeply involved in the process of setting up PHOs described earlier in this paper, gave this as his summary of what was involved.[5] It well describes my experience too.

[5] Simon Harding, HVDHB, in a presentation to the Ministry of Health conference: Primary Focus 2 Conference: Moving in the Right Direction, 10-12 March 2005.

- Time!
- Community engagement and collective decision-making takes time
- Working through differences and coming to a consensus demands time and energy
- Buy-in and ongoing support from board and senior management critical to success
- Keeping stakeholders informed throughout
- Current solution isn’t necessarily the final solution.

Thanks for the opportunity to share our experience. For me, engagement with our community is exciting and positive. I hope it is for you too.

Kia a koutou katoa, no te ao whanui, tena koutou katoa.