PROMOTING PUBLIC HEALTH AND WELLBEING IN YOUR COMMUNITY

June 2010
People coming together to share thoughts and ideas become the repositories of valuable knowledge and expertise. These taonga can be gifted to others so that:

- Through further discussion comes understanding
- By understanding comes light
- Through light comes wisdom
- Through wisdom comes well-being

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1 As quoted on Auckland Regional Public Health Services website, [http://www.arphs.govt.nz/](http://www.arphs.govt.nz/)
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PROMOTING PUBLIC HEALTH AND WELLBEING IN YOUR COMMUNITY

1. Overview

1.1 Who is this guide for?

Have you ever wondered what practical things you could do to improve the health and wellbeing of your local community? If so, this Public Health Association New Zealand (PHANZ) guide to Promoting Public Health and Wellbeing in Your Community is for you.

You may be one or more of the following:

- A voter in local government and District Health Board elections
- Seeking election to a Regional, District or City Council or a DHB, or already are a Councillor or Board member
- Working for a Regional, District or City Council
- Working for a DHB, a PHO, a Maori or other community-based health or welfare organisation.
- A local citizen who benefits from the many public health services and community outcomes that the above organisations individually or collectively deliver.

Achieving better public health outcomes at the local or national level require collaborative action by lots of different people. So whatever roles you play in your community, your active involvement matters.

1.2 How can this guide help you?

The purpose of this guide is to equip you with knowledge, information, concepts and skills that will enable you to work effectively with others to improve health and wellbeing in your community.

In particular, this guide gives you the low down on:

- what ‘health’ and ‘public health’ really mean, and their relationship to community wellbeing

- key insights from international experts on what it takes to improve public health and community wellbeing locally, nationally and globally
• the roles, responsibilities and processes that key government, health and other organisations currently play in promoting public health and wellbeing in New Zealand communities— including territorial local authorities, District Health Boards and their public health arms and Primary Health Organisations

• key questions that decision-makers in governance, management and service delivery roles need to ask, and be asked – to help ensure that together we do achieve better community health outcomes.
2. **What is Public Health and how does it relate to Community Wellbeing**

2.1 *What does ‘health’ mean?*

To understand what public health really means, we need to begin with what health means. That will give us a firm foundation for then identifying what distinguishes public health from other health arenas (in the next section.)

Throughout this guide we use the definition of health adopted by the World Health Organisation. The definition originated in the Alma-Ata Declaration signed by participants at a WHO international conference on Primary Health Care in 1978. The Alma-Ata Declaration states that health is “*a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity*”.

The Alma-Ata Declaration also said a number of other important things about health that PHANZ endorses. Health is characterised as a fundamental human right and attaining the highest possible level of health as an important world-wide social goal. Furthermore the Declaration recognises that realising this goal requires the action of many other social and economic sectors in addition to the health sector.

The importance of recognising the breadth of the determinants of health is further emphasised by our own Public Health Advisory Committee. Their research has revealed that “*the strongest influences on people’s health come from factors outside the health system. They include the social, cultural, physical and economic environments in which people live.*”

Finally, a holistic model of Maori health called Te Whare Tapa Whā also reinforces how multi-dimensional health is, and how inter-dependent the different dimensions of health are. In this model, developed by Mason Durie in 1985 and visually depicted below, the four cornerstones (or dimensions) of Māori health are represented by the four walls of a wharanui (meeting house). Each wall is necessary to the strength and symmetry of the building, and they are:

- Te taha hinengaro (mental and emotional health)

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5 The source of this visual depiction of Te Whare Tapa Whā is the Community and Public Health website of the Canterbury District Health Board, refer [http://www.cph.co.nz/Images/TeWhareTapaWha.gif](http://www.cph.co.nz/Images/TeWhareTapaWha.gif)
• Te taha wairua (spiritual health)
• Te taha tinana (physical health); and
• Te taha whānau (family and community or social health).

A key insight from Te Whare Tapa Whā is that should any wall be missing or become damaged, the person or collective may become damaged, out of balance and unwell.

2.2 What does ‘public health’ mean?

Sir Donald Acheson provided the most widely quoted definition of public health in a report to the United Kingdom government in 1988. He saw public health as “the science and art of promoting health, preventing disease and prolonging life through the organised efforts of society.” Implicit in this definition are a number of key things that distinguish public health from personal health, and public health interventions from personal health services.

Firstly, public health is about keeping people well, rather than treating their diseases, disorders and disabilities after they have emerged. That is why Sir Donald’s definition of public health emphasises promoting health, preventing disease and prolonging life.

Secondly, public health focuses on populations, not individuals. Public health is therefore often described as being about erecting fences at the top of cliffs (to protect the many), rather than sending ambulances to the bottom (to treat the few who fall off).

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Thirdly, the adjective ‘public’ in ‘public health’, has two meanings - both of which are important. So far we have noted that it means the ‘health of the public’ (that is, involving the health of groups or populations rather than individuals). The second meaning of public is implicit in the last part of Sir Donald’s definition of public health, which refers to “the organised efforts of society”. In other words, public health concerns improving the health outcomes of population through interventions that require collective efforts, often organised by public (that is, government) institutions.

Finally, there are two other key aspects of good public health worth noting. They are that public health practice is:

- evidence-based, not anecdotally based; and
- community-focused and defined.

In the words of Anne Morrison, Unit Manager, Population Health Service, Waikato District Health Board: "Public health is about using evidence-based prevention and intervention strategies to help communities grow their own ability to address the issues that affect their population."8

### 2.3 Relationship between health and other factors affecting wellbeing

Clearly health is central to, but only one of the many factors that contribute to both individual and community wellbeing. As Figure 1 shows, overall community wellbeing or public health results from complex links between the natural and physical/built environment, the social, economic and cultural environment, individual behaviours and risk factors, and the health and disease status of the people in the community.

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8 Anne Morrison, as quoted on the Ministry of Health website, viewable at: [www.publichealthworkforce.org.nz/What%20is%20public%20health%2010.aspx](http://www.publichealthworkforce.org.nz/What%20is%20public%20health%2010.aspx)
Figure 1: Factors contributing to public health and community wellbeing

9 Auckland Regional Public Health Service (12 December 2006), Presentation on Improving Public Health and Wellbeing through Well Managed Urban Development: Introduction to ARPHS, Slide 6
3. International Milestones in Public Health

Beyond the 1978 Alma-Ata Declaration already mentioned in section 2.1, people with a public health background generally cite the other major landmarks in international thinking about public health as being the:

- Ottawa Charter for Health Promotion (1986);
- Bangkok Charter for Health Promotion in a Globalized World (2005); and
- WHO Commission on Social Determinants of Health (2008).

The insights gained at these watershed international gatherings can help us craft effective public health actions in our own communities. They provide some conceptual frameworks and checklists that are of relevance whether you are working at the national, regional, local or organisation level.

This section provides a high-level overview of the approach advocated in each of these three landmark international documents. More detail on the approach advocated by each document is provided in Annex 1.

3.1 The Ottawa Charter

In 1986 the United Nations World Health Organisation sponsored the first international conference on health promotion in Ottawa, Canada. Experts attending from around the world developed the Ottawa Charter for Health Promotion: an international framework for promoting health and achieving health for all by 2000 or beyond.

The Ottawa Charter defines health promotion as the process of enabling people to increase control over and improve their health. It recognises that to reach a state of complete physical, mental and social well-being individual or groups must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. To achieve this, the basic pre-requisites individuals and groups require are: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.

Key health promotion themes

Four key themes for health promotion action in the Ottawa Charter are:

- Advocate for good health - because it is a major resource for social, economic and personal development and an important dimension of quality of life
• Enable men and women to take control of those things which determine their health and reduce health inequities - because equal opportunities and resources are needed to enable all people to achieve their fullest health potential

• Mediate between central and local government agencies, professional groups, industry, and voluntary organisations - in health and other social and economic sectors - to promote the health of individuals, families and communities. This is necessary because the prerequisites and prospects for health cannot be ensured by the health sector alone.

• A ‘one size fits all’ approach is not feasible in health promotion – to be successful, strategies and programmes must be adapted to local needs and possibilities, and must take into account differing social, cultural and economic systems.

Components of the framework for health promotion

The framework for health promotion action advocated in the Ottawa Charter has five key components:

1. Build healthy public policy – all policy makers across all sectors being aware of the health consequences of their actions and taking responsibility for using diverse policy instruments to ensure safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

2. Create supportive environments – encourage reciprocal maintenance, whereby we take care of each other, our communities and our natural and built environment so they generate living and working conditions that are safe, stimulating, satisfying and enjoyable.

3. Strengthen community actions - use community development strategies to empower communities to set their own priorities, make decisions, plan strategies and implement them to achieve better health

4. Develop personal skills – support learning throughout life to increase the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

5. Reorient health services: encourage individuals, community groups, health professionals, health service institutions and government to work together to develop an evidence-based health care system that moves beyond providing clinical and curative services to being more focused on health promotion and the total needs of the individual as a whole person.

6. Move into the Future: evolve into a society where the everyday settings in which we learn, work, play, love and live create conditions that allow the attainment of health by all its members.
3.2 The Bangkok Charter

After the Ottawa Charter was adopted in 1986, WHO Member States signed a significant number of resolutions at national and global level in support of health promotion, but these have not always been followed by action. In 2005 WHO called together experts from its Member States to examine and advise on how to close this implementation gap and move to policies and partnerships for action. The result is known as the Bangkok Charter for Health Promotion in a Globalised World.\(^\text{10}\)

The Bangkok Charter complements and builds upon the values, principles and action strategies for health promotion established by the Ottawa Charter. It identifies actions, commitments and pledges required to address the determinants of health and make progress towards a healthier world.

Required actions

Health promotion has an established repertoire of proven effective strategies which need to be fully utilised. To make further advances in implementing these strategies, the Bangkok Charter recommends that all sectors and settings must act to:

- **advocate** for health based on human rights and solidarity
- **invest** in sustainable policies, actions and infrastructure to address the determinants of health
- **build capacity** for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy
- **regulate and legislate** to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people
- **partner and build alliances** with public, private, nongovernmental and international organizations and civil society to create sustainable actions.

Key commitments

The four key commitments of the Bangkok Charter are to make the promotion of health:

1. central to the global development agenda
2. a core responsibility for all of government
3. a key focus of communities and civil society

4. a requirement for good corporate practice.

3.3 WHO Commission on Social Determinants of Health

The most recent international landmark publication on action to improve public health is the 2008 report of the WHO Commission on Social Determinants of Health. The report is entitled ‘Closing the gap in a generation: health equity through action on the social determinants of health’.

The Commission - constituting 19 international experts with a blend of political, academic and advocacy experience- spent three years gathering and evaluating evidence on the significant inequities to health existing between and within countries. Their objective was to determine what causes health inequities and what needs to be done by whom if the health of different groups is to be made equal.

The Commission found that social injustice is killing people on a grand scale. They concluded that the poor health of the poor, the social gradient of health within countries, and the marked health inequities between countries are caused by:

- the unequal distribution of power, income, goods and services, globally and nationally
- the consequent unfairness in their access to health care, schools and education, their conditions of work and leisure, their homes, communities, towns, or cities - that significantly diminish the chances of the poor and ill leading a flourishing life.

The Commission concluded that this unequal experience of health-damaging experiences is not in any sense a ‘natural’ phenomenon, but the result of a toxic combination of poor social policies and programme, unfair economic arrangements, and bad politics. Together the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.

The Commission calls for closing the health gap in a generation – an aspiration that they believe is achievable if we use the knowledge that exists to make the huge and achievable differences in peoples life chances that will result in marked improvements in health equity.

PHANZ believes that the Commission’s diagnosis is just as relevant to New Zealand as to other countries. Here as elsewhere in the world, factors like housing, education and income contribute to a person’s health, just as much as their physical makeup or behaviour. The opportunity to have a healthy life is not equal across all New Zealanders; it is still linked to social and economic circumstances, in particular childhood deprivation. This means many Maori and other New Zealanders have poorer health, reduced quality of life and early death.
The Commission makes three over-arching recommendations or principles of action to form the basis of a coherent approach to reducing inequalities – and identifies what must be done to achieve each principle of action.

1. *Improve daily living conditions* by:

- Investing in equity in the early years
- Developing healthy places, and healthy people
- Fair employment and decent working conditions
- Social protection across the life course
- Universal health care

2. *Tackling the inequitable distribution of power, money and resources* by:

- Health equity being a focus for all policies, systems and programmes
- Fair financing
- Market responsibility
- Gender equity
- Political empowerment, inclusion and voice
- Good global governance

3. *Measuring and Understanding the Problem and Assessing the Impact of Action* by:

- Setting up national and global health equity surveillance systems
- Creating organisational space and capacity to act effectively on health inequities
4. The New Zealand Context

4.1 Overview

To apply the insights gained from international thinking on how to effectively promote public health at the community level, we need to understand the New Zealand context in which to apply them. There are a number of different national, regional and local organisations that can, individually or collectively, influence public health outcomes in your community. The more you understand about who these entities are and how they work, the more likely it is that you can influence them to take effective actions.

The main institutions/organisations that could contribute to improving public health outcomes in your community are either in the local government sector, in the health sector or are other central government agencies operating in related sectors, some with their own local delivery arms. These institutions have evolved as Government and circumstances have changed. The purpose of this section of the guide is take the local government sector, health sector and other related agencies in turn, to give you a snapshot as at mid 2010 regarding:

- Who the main organisations are
- What their respective roles are (with a particular focus on their relationship to public health and community wellbeing)
- What legislative mandate they operate under
- The scale of their operations.

4.2 The Local Government Sector

4.2.1 Overview

Local Government plays a vital role in promoting the wellbeing of New Zealanders and New Zealand communities. Effective local government provides communities with a say about their resources and the decisions that affect their well-being, now and in the future.\[11\] They support local communities by providing them with a substantial range of basic services that include physical infrastructure, community infrastructure and regulatory functions.

Collectively, as at 30 June 2008, local authorities in New Zealand had:

- 1025 elected members plus 721 community board members

\[11\] Department of Internal Affairs (2008), Briefing the the Incoming Minister of Local Government, p. 5.
- approximately 40,000 employees
- total assets of $83.6 billion
- an annual operating income of $6.2 billion (accounting for about 5% of gross national expenditure)
- a combined operating surplus of $159 million
- a total rates take of $3.5 billion
- an annual income from sales of good and services of $1.1 billion
- an annual investment income of $327 million

**Major local government organisations and their areas**

The main players in New Zealand’s local government sector are currently the 96 local authorities, constituting:

- 12 regional councils
- 73 territorial authorities, of which:
  - 57 are district councils and 16 are city councils
  - 5 also carry out the roles of regional councils

The geographic boundaries of the local authorities are shown in Figure 3 (North Island) and Figure 4 (South Island).

Beyond regional councils and territorial local authorities, the other main organisations in the local government sector are:

- Community Boards
- the Department of Internal Affairs.
- the Local Government Commission
- Local Government New Zealand
- the Society of Local Government Employees and Managers (SOLGEM)

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12 These are Nelson City Council, the Gisborne, Marlborough and Tasman District Councils, and the Chatham Islands Council. The first four are sometimes referred to as unitary councils.

13 Source: http://www.lgnz.co.nz/lg-sector/maps/south3.gif
Figure 3: Geographic Boundaries of North Island Regional and Territorial Local Authorities
4.2.2 Regional councils - roles

Regional councils typically manage the following functions throughout the geographic areas of one or more territorial local authorities:¹⁴

- Managing the effects of using freshwater, land, air and coastal waters, by developing regional policy statements and issuing of consents
- Managing rivers, mitigating soil erosion and flood control
- Regional civil defence emergency management and flood control
- Regional land transport planning and contracting passenger services

Regional economic development and tourism
Harbour navigation and safety, oil spills and marine pollution
Regional parks

4.2.3 Territorial authorities (city and district councils) - roles

The roles of territorial authorities (city and district councils) include\textsuperscript{15}:

- Controlling the effects of land use (including hazardous substances, natural hazards and indigenous biodiversity), noise, and the effects of activities on the surface of lakes and rivers
- Providing local infrastructure, including water supply, waste and storm water, sewerage and roading network
- Environmental safety and health, district civil defence emergency management and preparedness, building control, public health inspections, dog control and other environmental health matters
- Social and community development activities, including providing community centres, community grant funding, social housing and community safety initiatives
- Recreation, leisure and culture services, including provision of recreation facilities and programmes (including swimming pools), public libraries, parks and open space, and art and cultural programmes and facilities
- Economic development and tourism promotion.

Legislative mandate for local government

The Department of Internal Affairs describes the legislative framework for local government as being focused “on the transparency of council decision making, efficiency and effectiveness, and accountability.”\textsuperscript{16} It is made up of three key acts, the Local Government Act 2002, the Local Electoral Act 2001 and the Local Government Rating Act 2002.

The overall objective of the three Acts is to enable local authorities to be responsive to the current and future needs of the communities they represent, and to provide greater scope for those communities to participate in the decision-making processes that determine what their local authorities do. The three acts seek to provide an appropriate balance between flexible local decision-making and the rights of individuals and communities to understand and influence what the local authority does.

\textsuperscript{15} Ibid, Annex II, p.
\textsuperscript{16} Ibid, p.8.
The respective roles of the three key acts are as follows:

- **Local Government Act 2002**: The purpose of this enabling (rather than prescriptive) Act is to provide for democratic and effective local government that recognises the diversity of New Zealand communities. Local authorities must promote the social, economic, environmental and cultural well-being of communities, in the present and for the future. The Act’s broad empowering provisions are intended to allow local authorities, in consultation with their community, to decide on the priorities for their district or region, and how the provision of local services is to be managed and funded. Although the Act provides local authorities with more flexible powers and tools, it balances this with explicit decision-making, consultation, strategic planning and accountability expectation. It also includes modernised and simplified governance procedures, regulatory powers and processes, and a limited number of restrictions on council decision-making.

- **Local Electoral Act 2001**: This act prescribes the conduct of local authority elections and polls. It also provides opportunities and procedures to allow local communities to choose local electoral systems (i.e. First Past the Post or Single Transferable Vote), and for reviews of representation arrangements for local authority elections, the constitution of community boards and Maori wards and constituencies. The Act also provides the basis for District Health Board and Licensing Trust elections.

- **Local Government Rating Act 2002**: This act provides modern and flexible rating mechanisms that are the primary means by which councils raise revenue from their communities. The exercise of rating powers is subject to transparency, consultation and accountability requirements under the Local Government Act 2002.

Under the Act, the Long-Term Council Community Plan (LTCCP) is now the basis of a local authority’s annual financial and performance accountability to its community,

Under the current Local Government Act councils are subject to planning and management disciplines including:

- preparing annual plans and budgets in consultation with their communities
- reporting annually on performance in relation to plans
- preparing long-term financial strategies including funding, borrowing management and investment policies
- adopting accrual accounting practices
- valuing their assets
- separating policy/regulatory from operational functions

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17 Local Government Act (2001), Section 10
• preparing policies and plans concerning other functions, especially resource management, land transport and biosecurity.\textsuperscript{18}

The Local Government Act 2002 outlines some new processes for local authority working, which include requirements to:

• Make itself aware of, and have regard to, the views of all its communities
• Providing opportunities for Maori to contribute to its decision-making processes
• Collaborating and co-operating with other local authorities and bodies as it considers appropriate to promote or achieve its priorities and desired outcomes, and make efficient use of resources
• Taking a sustainable development approach, in which a local authority should take into account:
  o The social, economic and cultural wellbeing of people and communities;
  o The need to maintain and enhance the quality of the environment; and
  o The reasonably foreseeable needs of future generations.\textsuperscript{19}

Councils are required to identify ‘community outcomes’ every six years. This process is about local people defining the things that they think are important for their wellbeing. Under the Act, community outcomes are:

• identified through a consultation process, led by local authorities
• described by local authorities in their long-term council community plans
• monitored by local authorities, with progress reported regularly
• used as a focus for encouraging local authorities, central government agencies, and other organisations to work together

Councils also have responsibility for reporting on progress towards achieving community outcomes at least once every three years – though they don’t have sole responsibility for achieving them. Their responsibility is to record the actions that the and other collaborators and partners will take in their Long Term Community Plans (LCTP), and to facilitate action to help the community achieve them. The Act encourages Councils to collaborate and partner with a wide range of other local stakeholders including:

• iwi/Maori organizations
• community and voluntary sector groups and agencies
• government agencies and departments
• business and environmental interests
• other local authorities. (note DHBs are not on the list).

\textsuperscript{18} Local Government New Zealand, http://www.lgnz.co.nz/lg-sector/
\textsuperscript{19} Local Government Act (2002), Section 14.
Depending on the what communities raise and how local authorities respond to them,, the 2002 Act could see:

- Councils informing or advocating to other agencies about local community outcomes and priorities
- Some councils entering into new service provision roles
- Councils acting as a strategic co-ordinator, bringing a range of agencies together to work collaboratively around particular local community outcomes.

While the local government legislation does not specifically refer to public health, as discussed earlier in this guide, community wellbeing which is at the core of the legislation is a closely related concept. The Act defines this as social, economic, environmental or cultural wellbeing.

The financial year 2009/10 will be the first year in which annual reports are prepared on the basis of the new 2009-19 LTCCPs. For each group of activities of the local authority, the annual report must also:

- report the results of any measurement of progress in achieving community outcomes; and
- describe any identified effects that any activity within the group of activities has had on the social, economic, environmental, or cultural well-being of the community.

In addition to information about any measurement by a local authority of progress in achieving community outcomes and any identified effects of activities, the annual report must include an audited statement of service performance:

- comparing actual levels of service for each group of activities against the intended levels of service (as set out in the LTCCP for that year); and
- giving the reasons for any significant variation between actual and expected levels of service provision.

The annual report must also include one further audited statement that:

- describes any significant acquisitions or replacements of assets in the year and giving reasons for them; and
- gives the reasons for any significant variation between the acquisitions and replacements projected in the LTCCP and those actually made.

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21 Ibid, p.19
### 4.2.4 Community Boards

There are also 144 community boards. Their powers are either delegated by the relevant territorial authority or prescribed by the Order in Council constituting its community. Community boards are filled largely by election although territorial authorities have the right to appoint a minority of its members.

### 4.2.5 The Department of Internal Affairs

The Local Government and Community branch of the Department advises the Minister of Local Government on the framework and system of local government and its overall effectiveness. The branch also plays a key co-ordinating role by bringing together local government and central government through administering the Central-Local Government Forum, Central Government Interagency Group and other national and regional groups of central and local government officials. They support central government engagement with local government at a regional level on key urban and

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<th>Annual report (clause 15 of Schedule 10 of the Act) (reporting phase)</th>
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<td>Describe the community outcomes, how they have been identified, how the local authority will contribute to their achievement and work with others to further them, and how they fit with other local authority strategies and processes.</td>
<td>In relation to each group of activities, report the results of any measurement carried out during the year, of progress in achieving community outcomes.</td>
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<td>State the measures that will be used to assess progress in achieving community outcomes.</td>
<td>For each group of activities, identify the activities within them.</td>
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<td>State how the local authority will monitor and report on the community's progress in achieving community outcomes (which must not be less than once every three years).**</td>
<td>Identify the rationale for delivery of the group of activities (including the community outcomes to which the group of activities primarily contributes).</td>
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<tr>
<td>For each group of activities, identify the activities within them.</td>
<td>Identify the community outcomes to which the group of activities primarily contributes.</td>
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<tr>
<td>Identify the rationale for delivery of the group of activities (including the community outcomes to which the group of activities primarily contributes).</td>
<td>Outline any significant negative effects that any activity within the group of activities may have on environmental, economic, social, or cultural well-being.</td>
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<tr>
<td>State intended levels of service provision for each group of activities.</td>
<td>Describe any identified effects that any activity within the group of activities has had on environmental, economic, social, or cultural well-being.</td>
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<tr>
<td>Identify detailed information about assets required for each group of activities, including information about forecast acquisition and replacement.</td>
<td>Contain an audited statement about acquisition and replacement of assets.</td>
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regional issues, and encourage information sharing. They also work at the interface between local and central government to promote an integrated approach to community outcomes.

### 4.2.6 The Local Government Commission

The Local Government Commission is an independent statutory body whose main role is to make decisions on the structure and representation requirements of local government in New Zealand. The Commission has three members, appointed by the Minister of Local Government.

### 4.2.7 Local Government New Zealand (LGNZ)

LGNZ represents the local government sector, and particularly the elected members of local government. It is supported by a number of full-time staff. LGNZ describes itself as “the organisation that represents the national interests of councils of New Zealand. As the champion of best practice in the local government sector, we provide policy, advice and training to councils.”

### 4.2.8 Society of Local Government Managers (SOLGM)

The NZ Society of Local Government Managers (SOLGM) represents senior local government officers. As local government's professional management organisation, SOLGM builds capability and promotes work excellence among local government managers and staff through membership services, professional development and training, good practice resources and influencing policy development and implementation.

### 4.3 The New Zealand Health Sector

#### 4.3.1 Overview

In New Zealand health and disability services are delivered by a complex system of dispersed and specialised organisations and people. The players in the system have different histories, interests and connections. To function effectively they must be willing and able to work together across the system to ensure coherence, consistency and sustainability.

Most of the day-to-day business of the system, and around three quarters of the funding, is administered by District Health Boards (DHBs). Under this devolved system DHBs plan, manage, provide and purchase services for the population of their district. This includes funding for primary care, public health services, aged care services and services.

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22 http://www.lgnz.co.nz/
provided by other non-governmental health providers including Māori and Pacific providers.

Other key players in the health sector, with particular relevance to public health are:

- the public health arms of DHBs
- the Ministry of Health (and the National Health Board)
- Public Health Organisations
- A wide variety of non-governmental organisations, which include
  - Locally-based Māori health organisations
  - Nationally based health and disability providers (like IHC, Plunket etc)
- The Health and Disability Commissioner
- DHBNZ

The health sector also includes (but details about their roles are not provided in this guide):

- many different types of private health practitioners and businesses (including general medical practitioners, midwives, pharmacists, physiotherapists, laboratories, radiologists, chiropractors, osteopaths, medical specialists, private hospitals)
- professional and regulatory bodies for all health professionals, including all medical and surgical specialist areas, nurses and allied health groups
- a range of educational and research institutions that impact on demand and prioritisation of services as well as training of the workforce
- many consumer bodies and non-governmental organisations (NGOs) that provide services and advocate the interests of various groups, and
- more formal advocacy and inquiry boards, committees and entities.

All of these groups and individuals can have a significant influence over the priorities and demands on the system, and the linkages between them are not always clear. Good relationships between the various players in the system are essential for the effective operation of the system.

4.3.2 District Health Boards

District Health Boards (DHBs) provide or fund a specified range of health and disability services. The 21 DHBs have existed since 1 January 2001 when the New Zealand Public Health and Disability (NZPHD) Act 2000 came into force.
Under the NZPHD Act, DHBs must:

- improve, promote and protect the health of communities
- promote the integration of health services, especially primary and secondary services
- promote effective care or support of those in need of personal health services or disability support
- promote independence, inclusion and participation in society for people with disabilities
- reduce health outcome disparities between various population groups.

Figure 2 shows the DHB boundaries while Table 1 shows the names, population sizes and budget sizes of the 21 DHBs as at September 2007.  

The Government also expects DHBs to show a sense of social responsibility, foster community participation in health improvement, and uphold the ethical and quality standards expected of providers of services and public sector organisations.

**DHB governance**

DHBs are governed by boards comprising up to 11 members: seven are elected by the public every three years, and up to four additional members can be appointed by the Minister of Health.

DHB elections are held concurrently with local government elections. DHB appointments are largely made in the weeks following the election and terms of office are timed to coincide with those of elected members. The last DHB elections were held in October 2007 and the next will be held in October 2010.

DHB boards are required to have three statutory advisory committees: a hospital advisory committee, a community and public health advisory committee, and a disability support advisory committee. Boards may also set up additional committees to suit their needs, such as audit and risk committees, and Māori or Iwi relationship bodies. Committee members can be either board members or members of the public.

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23 Ministry of Health (November 2008). The New Zealand Health and Disability System: Organisations and Responsibilities – Briefing to the Minister of Health, p.25
Figure 2: DHB boundaries

Table 1: DHB populations & expenditure

<table>
<thead>
<tr>
<th>DHB</th>
<th>Population (000s) approximate</th>
<th>Annual funding ($ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitemata</td>
<td>516</td>
<td>$998</td>
</tr>
<tr>
<td>Canterbury</td>
<td>491</td>
<td>$1,103</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>468</td>
<td>$916</td>
</tr>
<tr>
<td>Waikato</td>
<td>355</td>
<td>$770</td>
</tr>
<tr>
<td>Auckland</td>
<td>439</td>
<td>$673</td>
</tr>
<tr>
<td>Capital &amp; Coast</td>
<td>282</td>
<td>$531</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>204</td>
<td>$485</td>
</tr>
<tr>
<td>Otago</td>
<td>185</td>
<td>$415</td>
</tr>
<tr>
<td>MidCentral</td>
<td>165</td>
<td>$368</td>
</tr>
<tr>
<td>Northland</td>
<td>154</td>
<td>$383</td>
</tr>
<tr>
<td>Hawke’s Bay</td>
<td>153</td>
<td>$355</td>
</tr>
<tr>
<td>Hutt</td>
<td>141</td>
<td>$283</td>
</tr>
<tr>
<td>Nelson Marlborough</td>
<td>135</td>
<td>$307</td>
</tr>
<tr>
<td>Southland</td>
<td>110</td>
<td>$232</td>
</tr>
<tr>
<td>Taranaki</td>
<td>107</td>
<td>$253</td>
</tr>
<tr>
<td>Lakes</td>
<td>102</td>
<td>$229</td>
</tr>
<tr>
<td>Whanganui</td>
<td>63</td>
<td>$170</td>
</tr>
<tr>
<td>South Canterbury</td>
<td>55</td>
<td>$137</td>
</tr>
<tr>
<td>Tairawhiti</td>
<td>45</td>
<td>$113</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>39</td>
<td>$99</td>
</tr>
<tr>
<td>West Coast</td>
<td>32</td>
<td>$101</td>
</tr>
</tbody>
</table>

Source: Statistics NZ population projections, September 2007
**DHBs and Māori**

The role of DHBs in the NZPHD Act identifies the need to recognise and respect the principles of the Treaty of Waitangi and to enable Māori to contribute to decision-making on, and to participate in, the delivery of health and disability support services.

**Māori participation in decision-making**

The Minister of Health has the responsibility, under the NZPHD Act, to ‘endeavour to ensure’ there are at least two Māori board members on each DHB. Many DHBs also have formal arrangements with Iwi or local Māori groups for example, through a Māori relationship board. The Māori relationship board model assists DHBs to develop effective Māori health strategies by enabling local Iwi/Māori to influence the planning, purchasing, delivery and monitoring of health services for Māori in their region. Māori relationship boards provide independent advice to DHBs and typically comprise representatives from local Iwi and hapū (manawhenua and/or matawaka), Māori groups such as runanga, and individual Māori with an interest or involvement in health issues.

**Māori involvement in service delivery**

DHBs also have a role in fostering Māori involvement in service delivery. The main way this is interpreted is through building a stronger Māori health and disability workforce and by supporting Māori health and disability providers in their districts.

**Improving Māori health outcomes**

One of the objectives of DHBs – as set out in the NZPHD Act – is to reduce disparities by improving health outcomes for Māori and other population groups. This starts with good planning and DHBs are required to undertake health needs assessments to understand the health needs (and inequalities) in their communities and to plan services, through district strategic plans, around these needs.

The New Zealand Health Strategy states that the principle of acknowledging the special relationship between Māori and the Crown should be reflected across the health sector. DHBs must ensure their district strategic plans reflect the overall direction established in the New Zealand Health Strategy and the New Zealand Disability Strategy. DHBs also have a role in implementing He Korowai Oranga (the Māori health strategy), which provides a framework for action to improve Māori health and reduce inequalities. DHBs also have specific responsibilities for actions in Whakatātaka Tuarua, the second Māori Health Action Plan.

### 4.3.3 Public Health Units (PHUs)

Regional public health services are delivered by 12 DHB-owned public health units (PHUs) and various non-governmental organisations (NGOs). DHB-based services and NGOs each deliver approximately half of such services.

Public health units focus on ‘core public health services’, as specified in the *Public Health Services Handbook*, including environmental health, communicable disease control, tobacco control and health promotion programmes. Many of these services
include a regulatory component performed by statutory officers\textsuperscript{24} appointed under a various statutes, though principally under the Health Act 1956. These statutory officers are employed by DHBs but are personally accountable to, and subject to, direction from the Director-General of Health.

The 12 Regional Public Health Units and the respective DHB areas that they provide public health services for are:

- Northland Primary and Community Health Services
- Auckland Regional Public Health Services (covering Auckland, Waitemata, and Counties Manakau DHBs)
- Waikato Public Health Unit
- Toi Te Ora Public Health Unit (with offices in Tauranga, Whakatane and Rotorua covering Bay of Plenty and Lakes DHBs)
- Tairawhiti Public Health Unit
- Hawkes Bay Public Health Unit
- Taranaki Public Health Unit
- Mid Central Public Health Unit (covering both Mid Central and Whanganui DHBs)
- Hutt Valley Regional Public Health (covering Wellington, Wairarapa and the Hutt Valley DHBs)
- Nelson Public Health Unit (based in Nelson Marlborough DHB)
- Christchurch Community and Public Health (covering the West Coast, Canterbury and South Canterbury DHBs)

\textsuperscript{24}The principal statutory officers are designated by the Director-General of Health under the Health Act 1956. These officers, Medical Officers of Health and Health Protection Officers, are accountable to, and subject to direction from, the Director-General. This allows for central oversight of regulatory functions. The majority of these officers are employed in DHB-based public health units. The Director-General also appoints statutory officers under a range of other Acts, in particular the Smoke-free Environments Act 1990, the Tuberculosis Act 1948 and the Hazardous Substances and New Organisms Act 1996. City and district councils also appoint Environmental Health Officers under the Health Act, who assist councils to perform their environmental health functions under the Health Act.

Four Ministry staff, including the Director of Public Health, are currently designated by the Director-General as Medical Officers of Health for all health districts. In effect this ensures that there are four ‘national’ Medical Officers of Health who are able to exercise powers if required throughout New Zealand.

Statutory officers and public health units also work with the Ministry’s Health and Disability Systems Strategy Directorate (Office of the Director of Public Health), Population Health Directorate and Health and Disability National Services Directorate, around ongoing technical, legislative and policy support, funding and co-ordination of service.
• Public Health South (covering Otago and Southland DHBs)

Service Specifications

The Ministry of Health purchases public health services from DHB Public Health Units and numerous NGOs in 12 service categories and the budget is allocated to these categories. (A thirteenth category, problem gambling, is currently being developed.) Service specifications have been developed for each category and relevant subcategories. Public Health providers are asked to prepare programme plans to address one or more service categories, based on the service specifications.

Public Health Regulatory Services - Generic

In regard to generic public health regulatory services: the health goal is to protect the health of the population by implementing and ensuring compliance with public health legislation as part of comprehensive public health programmes. Public health legislation provides a legal and administrative framework for managing risks, protecting public health and safety, implementing standards and informing the public about a range of public health and consumer issues and risks. Enforcement of public health legislation is one of a number of techniques available to the public health services but is usually used only when other techniques are insufficient to achieve necessary standards. Responsibility for public health legislation is shared between the Ministry of Health and Public Health Services (through designated officers).

The public health-related service categories and the main elements of each are summarised in Table 2:

Providers will discuss with their Portfolio Manager how their planning documents might address community-based programmes that cover several categories.

Each service specifications includes:

• health goal - the overall health goal for the service category

• a rationale and key issues - the key health issues at a national level and includes key issues which providers need to consider in their planning

• service objectives - the framework of the services the Ministry funds for the particular service category. However this may not be relevant to all providers

• components of service - the scope of services which may be provided across all providers for that service category. Some providers may specialise in only one or two components. Some regional providers will develop an integrated service plan that includes a balance of most of the components of service in their plan

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25 From Ministry of Health website, section on Public Health Services handbook/service specifications
Table 2: Public health service categories and what they encompass

<table>
<thead>
<tr>
<th>Physical Environment</th>
<th>Communicable Diseases</th>
<th>Social Environments</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Air quality (indoor and outdoor)</td>
<td>- Communicable disease control, communicable disease surveillance, and imported disease control</td>
<td>- Healthy cities and communities, and social environments</td>
</tr>
<tr>
<td>- Biosecurity and quarantine</td>
<td>- Immunisation promotion</td>
<td>- Health Promoting Schools - Healthy Schools – Kura Waira</td>
</tr>
<tr>
<td>- Burial and cremation</td>
<td>- Refugees and asylum seekers</td>
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<tr>
<td>- Contaminated land</td>
<td>- Needle exchange programme</td>
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<tr>
<td>- Drinking water quality</td>
<td></td>
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<td>- Early childhood centres</td>
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<tr>
<td>- Environmental noise management</td>
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<td>- Hazardous substances</td>
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<td>- Ionising/non-ionising radiation</td>
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<tr>
<td>- Public Health emergency planning and response</td>
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<td></td>
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<tr>
<td>- Recreational water (including Non-commercial Shellfish</td>
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<tr>
<td>- Growing Waters</td>
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<tr>
<td>- Resource management</td>
<td></td>
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<tr>
<td>- Sewage treatment and disposal</td>
<td></td>
<td></td>
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<tr>
<td>- Waste management (liquid and solid waste)</td>
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<td></td>
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<tr>
<td>- Other regulatory activities</td>
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<tr>
<td></td>
<td><strong>Well Child</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Promotion of Well Child</td>
<td></td>
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<tr>
<td></td>
<td>- Parenting support and skills promotion</td>
<td></td>
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<tr>
<td></td>
<td>- Prevention of hearing loss and children's audiability</td>
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<tr>
<td></td>
<td>- Prevention of Sudden Infant Death Syndrome (SIDS)</td>
<td></td>
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<td></td>
<td>- Rheumatic fever prevention</td>
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<td></td>
<td>- Oral health promotion</td>
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<td></td>
<td>- Melanoma prevention</td>
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<td></td>
<td>- Asthma prevention</td>
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<tr>
<td></td>
<td><strong>Screening</strong></td>
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<tr>
<td></td>
<td>- Cervical screening</td>
<td></td>
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<tr>
<td></td>
<td>- Breast screening</td>
<td></td>
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<tr>
<td></td>
<td><strong>Prevention of Alcohol and Other Drug Related Harm</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Prevention of alcohol related harm, liquor licensing, and substance misuse.</td>
<td></td>
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<tr>
<td></td>
<td><strong>Tobacco Control</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Smoking reduction programmes and smokefree environments</td>
<td></td>
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<tr>
<td></td>
<td><strong>Nutrition and Physical Activity</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Nutrition</td>
<td></td>
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<td></td>
<td>- Physical Activity</td>
<td></td>
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<tr>
<td></td>
<td>- Obesity</td>
<td></td>
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<tr>
<td></td>
<td><strong>Sexual Health</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Sexually transmitted diseases including HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Mental Health Promotion</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Mental health promotion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Suicide Prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Reducing Stigma and Discrimination</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Injury Prevention</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Unintentional injuries among children and young people</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Unintentional injuries among elderly people</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Intentional injury</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Public Health Infrastructure</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Strengthening public health action</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Workforce and sector development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Health education/health information resource development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Quality Plans</td>
<td></td>
</tr>
</tbody>
</table>

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26 Ministry of Health (2004?), Public Health Service Handbook, p.2,
service descriptions/activities - a menu of activities which a provider might plan to address the particular service component. One activity may address several components of service and a provider is not expected to carry out all activities. The list has not been designed to be prescriptive, but to give guidance on the types of activities that need to be included in the plan. Where service components are mandatory (e.g. for some regulatory services) this is noted in the specification.

references and supporting documents - a list of references and other relevant documents which may assist in planning.

4.3.4 The Ministry of Health

Role of the Ministry of Health

The Ministry of Health is the key agent of the Minister in the health and disability system. It provides a range of functions to support the Minister of Health and maintain the core of government’s responsibilities for the health and participation of New Zealanders. The Ministry is policy advisor, regulator, and funder and provider of services. It provides leadership across the system to improve performance. Although New Zealand has a devolved health and disability service model, the Ministry of Health continues to fund a broad range of national services (e.g. public health, screening, well-child, disability support services) and provide shared support services, such as the processing of payments on behalf of the sector and the maintenance of health information.

The Ministry’s goal is ‘Healthy New Zealanders’, and it aims to ensure that the health and disability support system works for all New Zealanders providing better health, reduced inequalities, better participation and independence, and trust and security.

Public health role of Ministry

The Ministry of Health is accountable to the Minister for discharging the Crown's responsibilities for public health protection and legislation. It also has health policy advice and public health purchasing roles. The Ministry of Health supports public health services and designated officers by:

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27 Public Health Services Handbook, pp 5-6
reviewing and developing public health legislation, standards, protocols, data definitions, manuals and service guidelines within the scope of public health protection and legislative services

designating, co-ordinating and directing statutory officers as required

establishing health districts

providing national leadership for public health protection and legislative services

providing training, advice and information to designated officers on public health legislation, methods and guidelines for administration and enforcement, legal precedents and limitations of the law and their statutory powers

assisting in the professional development of designated officers on legislation, policies and standards to ensure national consistency

providing designated officers with technical information and/or access to certain specialist technical, operational and legal advice on public health legislation to support their work

prioritising the activities and services to be provided in the case of a national or emergency response situation, communicable disease outbreak, civil defence emergency, or food or product recall

being the Government's health link with international organisations and foreign governments

giving effect to the Director-General of Health's primary and overall responsibility for health matters in mitigation, preparedness, response and recovery in relation to civil defence and public health emergencies

contributing to and, where appropriate, facilitating forums for public health services involving service providers and designated officers

collecting statutory reported information to support its function of monitoring the state of the public health and identifying public health needs.

National Health Board

In 2009 the Minister of Health, the Hon Tony Ryall appointed a Ministerial Review Group to advise him on improving the quality and performance of the public health system. Their brief included reviewing the existing systems for infrastructure and prioritisation, and advising improvements. As a result of their recommendations, a new National Health Board is being established as a unit within the Ministry of Health. It will provide a more focused national supervision of the $9.7 billion DHBs spend on hospital and primary health care. The NHB Advisory Board will advise the Minister and Director General on the NHB's performance and activities.
4.3.5 Public Health NGOs

Health and Disability NGOs include a wide range of organisations working in the health and disability system. They receive significant funding (in the order of $2–$4 billion per year) from both the Ministry and DHBs. Many are non-profit organisations and along with providing services to consumers they are a valuable contact with community level organisations.

4.3.6 Primary Health Organisations (PHOs)

Primary health organisations (PHOs) are funded by DHBs to provide a set of essential primary health care services to those people who are enrolled with the PHO. In particular, these comprise General Practice (GP) services.

Each PHO has a contract with its DHB to provide these services, called the Primary Health Organisation Agreement. The DHB is responsible for monitoring whether its PHOs are delivering services according to the agreement.

PHOs can take a variety of legal forms, such as non-profit companies, incorporated societies or trusts. PHOs are required to involve their communities in their governance processes, and must show they are responsive to communities’ priorities and needs.

A PHO provides services either directly by employing staff or through its provider members. These services should improve and maintain the health of the entire enrolled population, as well as providing first-line services to restore people’s health when they are unwell. The aim is to ensure GP services are better linked with other primary health services (such as allied health services) to ensure a seamless continuum of care, in particular to better manage long term conditions.

Although primary health care practitioners, such as General Practitioners (GPs) and allied health professionals, are encouraged to join PHOs, membership is voluntary. As at 1 July 2005, 3.85 million New Zealanders were enrolled with one of the 79 PHOs nationwide. A PHO Taskforce, comprising members from PHOs, meets every six weeks and gives advice to the Ministry from the PHO perspective. A community council is being established to provide the Ministry with advice on the Primary Health Care Strategy from a consumer/community perspective.

4.4 Other Central Government Agencies

4.4.1 Overview

There are many Government departments and crown entities that potentially have some impact on public health and community well-being, beyond the Ministry of Health and the Department of Internal Affairs. The other government agencies who are most likely to have a significant impact include:
Focus: “Social development is about addressing immediate needs while ensuring positive outcomes in the future. It is a planned process of improving people’s wellbeing, and of enabling communities to determine how they can achieve wellbeing for themselves. By helping to build successful individuals, MSD in turn helps build strong healthy families and communities.”

Major roles:

- Social policy and advice to government
- Statutory care and protection of children and young people, youth justice services and adoption services
- Delivery of employment and income support services and New Zealand Superannuation
- Administration of New Zealand's international welfare portability arrangements
- Providing student allowances and student loans
- The leadership and co-ordination of social support services, and funding to community service providers
- Access to a range of concessions and discounts.

Nature and scope of functions:

The Ministry of Social Development is the Government's lead provider of policy advice and services for children and young people, working age people, older people, families and communities. It provides services to the:

- Minister and Associate Minister for Social Development and Employment
- Minister for Senior Citizens
- Minister and Associate Minister for Disability Issues
- Minister for the Community and Voluntary Sector
- Minister of Youth Affairs
- Minister of Veterans' Affairs
- Minister responsible for Whānau Ora.

Throughout the country the Ministry has around 300 sites and provide services to more than 1.1 million clients.

The Ministry provides leadership and co-ordination among various government and non-government organisations to achieve improved results. The Ministry chairs the Social Sector Forum of Chief Executives, the Chief Executives' Group on Disability Issues, the Chief Executives' Group on the Community Sector, and participates in the Justice Sector Chief Executives Forum. The Ministry provides whole-of-social-sector second opinion advice to Government.

The Ministry includes three offices:

- **Office for Senior Citizens** - supporting the Minister for Senior Citizens to promote positive ageing and the interests of older people
- **Office for Disability Issues** - supporting the Minister for Disability Issues to oversee Government implementation of the New Zealand Disability Strategy and the UN Convention on the Rights of Persons with Disabilities addressing the challenges and advancing the interests of disabled New Zealanders, as well as supporting the Ministerial Committee on Disability Issues
- **Office for the Community and Voluntary Sector** - supporting the Minister for the Community and Voluntary Sector to strengthen the relationship between Government and the sector.

**MSD is structured into the following clusters:**

- **Policy** - the Social Sector Strategy group provides social sector-wide policy advice, policy advice on communities and community-government relationships, second opinion advice to Ministers and to the Cabinet Social Policy Committee. The group's evaluation, research and information provides a strong evidence base in support of the Ministry's advice, policy development and operational delivery. The Social Services Policy group provides advice on services for children and families, young people, working age New Zealanders and older people. This group includes the Ministry of Youth Development
- **Service Delivery** - provides services to clients through four service lines: Work and Income; Students, Seniors and Integrity Services; Child, Youth and Family; and Family and Community Services
- **Corporate** - supports the service delivery and policy clusters: People, Capability and Resources; Risk and Assurance; and Corporate and Governance.

**MSD administers the following Votes in 2010/2011:**

- Vote Senior Citizens:
- Vote Social Development:
- Vote Veterans' Affairs - Social Development:
- Vote Youth Development:

**MSD provides purchase, governance and ownership advice for the following Crown entities:**

- Children's Commissioner
- Families Commission
- New Zealand Artificial Limb Board
- Retirement Commissioner
- Social Workers Registration Board.

**MSD provides advice on appointments to the following statutory tribunals:**

- Social Security Appeal Authority
- Social Workers Complaints and Disciplinary Tribunal
- Student Allowance Appeal Authority.

**The key pieces of legislation MSD manages and administers are the:**

- Adoption Act 1955 (operational administration)
- Adoption (Intercountry) Act 1997 (operational administration)
- Adult Adoption Information Act 1985 (operational administration)
- Charities Act 2005
- Children, Young Persons, and Their Families Act 1989
- Children's Commissioner Act 2003
- Department of Child, Youth and Family Services Act 1999
- Department of Social Welfare Act 1971
- Disabled Persons Community Welfare Act 1975 (except Part 2A)
- Education Act 1989 (Part 25)
- Families Commission Act 2003
- Family Benefits (Home Ownership) Act 1964
- New Zealand Sign Language Act 2006
- New Zealand Superannuation and Retirement Income Act 2001 (Parts 1 and 4 and Schedules 1 and 6)
- Social Security Act 1964
- Social Workers Registration Act 2003
- War Pensions Act 1954 (operational administration for Veterans' Pensions)

**Learn more about MSD from:**

- The Ministry of Social Development website:  http://www.msd.govt.nz
4.4.3 The Ministry for the Environment (MfE)

Focus: Environmental stewardship for a prosperous New Zealand. The Ministry works to achieve high environmental standards for New Zealand, while sustaining and enhancing social and economic development.

Major roles:

The Ministry for the Environment advises the Government on all matters related to the environment and is one of its major advisers on the sustainable development of New Zealand. Ministry advice includes both international and domestic matters related to the environment and climate change.

An important element of our role in environmental stewardship is providing advice on effective environmental governance in New Zealand.

As part of this role the Ministry undertakes investigations, analysis, review and monitoring so that it can advise and report on a range of issues, including the state of New Zealand’s environment. The Ministry implements government decisions by leading ‘whole of government’ initiatives, coordinating the delivery of environmental programmes and administering legislation.

The Ministry works closely with other government agencies that have interests in the environment and resource management, particularly through a network of natural resources agencies which the Ministry chairs and supports. There is a similar forum for collaboration with regional councils.

Much of the responsibility for day-to-day environmental management is devolved to local government. This makes regional and district councils a critical part of environmental management in New Zealand. Central government provides guidance for their activities through national policy statements and national environmental standards (which are binding on local authorities), and also through professional development and sharing knowledge about best practice. The Ministry also monitors and publishes information about the health of the environment.

An Environmental Protection Authority has been established as a statutory office within the Ministry for the Environment to administer and make recommendations to the Minister for the Environment regarding the processing of nationally significant consent applications, plan changes, notices of requirement and certificates of compliance.

The Ministry also monitors the performance of the Environmental Risk Management Authority (a Crown entity) on behalf of the Minister for the Environment. The Authority makes decisions on applications to import, develop or field test or release new organisms; and to import or manufacture hazardous substances.

**MfE Legislative context**

The Ministry was established under the Environment Act 1986. The Ministry also has specific functions under the:

- Resource Management Act 1991
- Hazardous Substances and New Organisms Act 1996
- Ozone Layer Protection Act 1996
- Climate Change Response Act 2002

In addition to having policy advice and implementation activities, the Ministry also:

- administers government funding for grants under the Sustainable Management Fund
- administers the Environmental Legal Assistance Fund
- administers the Crown Contaminated Sites Remediation Fund
- monitors the performance of the Environmental Risk Management Authority (ERMA) on behalf of the Minister, which makes decisions on applications to introduce hazardous substances and new organisms to New Zealand.

**Learn more about Mfe from:**


### 4.4.4 Information sources about other government agencies

Table 3 provides information sources on the role and functioning of some other key government agencies.
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<tr>
<th>Agency</th>
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<td><a href="http://www.mfe.govt.nz">http://www.mfe.govt.nz</a></td>
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<td></td>
<td>Statement of Intent 2010-2013</td>
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<tr>
<td>New Zealand Transport Agency</td>
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<td><a href="http://www.nzta.govt.nz/">http://www.nzta.govt.nz/</a></td>
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<td>Statement of Intent 2010-2013</td>
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<tr>
<td>Department of Building and Housing</td>
<td>Website:</td>
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<td><a href="http://www.dbh.govt.nz">http://www.dbh.govt.nz</a></td>
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<td></td>
<td>Statement of Intent 2010-2013</td>
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<td>Housing New Zealand Corporation</td>
<td>Website:</td>
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<td><a href="http://www.hnzc.govt.nz">http://www.hnzc.govt.nz</a></td>
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<tr>
<td>Ministry of Economic Development</td>
<td>Website:</td>
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<td></td>
<td><a href="http://www.med.govt.nz">http://www.med.govt.nz</a></td>
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5. Questions for Candidates in Local Government Elections 2010

As a voter with an interest in improving public health and community wellbeing, the following are questions you could usefully ask the candidates for DHBs and local authorities in your community.

If you are planning to stand as a candidate for election to a DHB or a local authority, it would be very useful to consider what your views are on these questions, and how you would go about communicating those views to voters.

5.1 Questions for both DHB and Local Authority candidates

- What, in your view, are the areas of greatest concern about public health and wellbeing in our community?

- What do you think are the underlying causes of these public health and community wellbeing problems?

- If elected (to the regional/district/city council or the DHB), what will you do to ensure that the organisation addresses the underlying causes of these public health and wellbeing problems – where it is within their brief to do so?

- If elected, what actions will you take to foster strategic alliances between your organisation and other relevant organisations to:
  - collectively tackle these public health and community well-being problems?
  - Share information to develop a ‘joined up’ dataset on public health and community wellbeing - that allows identifying problems, setting goals, and monitoring achievements?

- If elected, would you lobby central government to better align the planning time frames and processes in the local government and health sector - so it is easier for them to plan and work together to improve public health and community wellbeing?

5.2 Questions For Local authority candidates only

- What community outcomes do you think should be included in the next Council Long Term Community Plan – and why?

- What performance measures would you advocate the Council collecting to monitor the achievement of community outcomes?
• What processes do you support your Council adopting, in regard to engaging Maori in planning and decision-making processes?

• Poverty is a significant cause of poor health and lack of social and economic wellbeing in our community. What role do you consider the Local Authority you are standing for should take in tackling local poverty issues - either working alone, or collaboratively with other local or central agencies?

5.3 Questions for DHB candidates only

• How would you help ensure that the public health agency that delivers public health services for the people in your DHB makes as effective a contribution as possible to the achievement of improved health outcomes?
Annex 1: More Information about Key Public Health-related International Documents

1. The Ottawa Charter

In 1986 the United Nations World Health Organisation sponsored the first international conference on health promotion in Ottawa, Canada. The experts from around the world participating were tasked with developing a framework that would be applicable internationally to the promotion of health – as defined at Alma-Ata, and would help achieve health for all by 2000 or beyond. In doing so they drew on:

- the experience of public health and the role of government (in its broadest sense)
- the role of education and the development of personal skills
- the “medical model” and the impact of appropriate services
- psychology and sociology in terms of the need for individuals and communities to feel supported in their endeavours;
- community development in terms of the impact of the energy released when individuals and communities feel that they have a degree of influence and control over their lives.

The framework they produced was published by WHO as the Ottawa Charter for Health Promotion. The Charter defines health promotion as the process of enabling people to increase control over and improve their health. It recognises that to reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

The Ottawa Charter recognises that improvement in individual and community health requires a secure foundation in some basic pre-requisites: peace; shelter; education; food; income; a stable eco-system; sustainable resources; social justice and equity.

‘Advocate’ is one key theme in the Ottawa Charter. The rationale is that good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

29 Williams, B (????), Health Promotion, Alma Atta and the Ottawa Charter, viewable at http://users.actrix.co.nz/bobwill/ottawa.doc
‘Enable’ is a second key theme in the Ottawa Charter. Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. The Ottawa Charter emphasises that this must apply equally to women and men.

A third key theme in the Ottawa Charter is ‘Mediate’. This is necessary because the prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

The Ottawa Charter also recognises that a ‘one size fits all’ approach is inappropriate. Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

The framework for Health Promotion Action advocated in the Ottawa Charter has five key components:

- build healthy public policy
- create supportive environments
- strengthen community action
- develop personal skills
- re-orient health services
- moving into the future.

*Build Healthy Public Policy*

The Ottawa Charter specifies that health promotion must go beyond health care, to be on the agenda of policy makers in all sectors and at all levels. It is crucial to direct them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

The Ottawa Charter also recognises that health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organisational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.
Health promotion policy requires identifying obstacles to adopting healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

*Create Supportive Environments*

The Ottawa Charter recognises that our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasised as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organises work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanisation - is essential and must be followed by action to ensure positive benefit to the health of the public. The Ottawa Charter specifies that protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

*Strengthen Community Actions*

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. The Ottawa Charter emphasises that at the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

*Develop Personal Skills*

The Ottawa Charter recognises that health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control
over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient Health Services

The Ottawa Charter notes that the responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services.

Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components. The Charter notes that reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organisation of health services which refocuses on the total needs of the individual as a whole person.

Moving into the Future

Finally the Ottawa Charter notes that health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members. Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

2. The Bangkok Charter

After the adoption of the Ottawa Charter in 1986, a significant number of resolutions at national and global level were signed in support of health promotion, but these have not always been followed by action. In 2005 WHO called together experts from its Member States to examine and advise on how to close this implementation gap and move to
policies and partnerships for action. The result is known as the Bangkok Charter for Health Promotion in a Globalised World.\(^{30}\)

The Bangkok Charter complements and builds upon the values, principles and action strategies for health promotion established by the Ottawa Charter. It identifies actions, commitments and pledges required to address the determinants of health in a globalised world through health promotion.

**Effective interventions**

The Bangkok Charter recognises that progress towards a healthier world requires strong political action, broad participation and sustained advocacy. Health promotion has an established repertoire of proven effective strategies which need to be fully utilised.

**Required actions**

To make further advances in implementing these strategies, The Bangkok Charter recommends that all sectors and settings must act to:

- **advocate** for health based on human rights and solidarity
- **invest** in sustainable policies, actions and infrastructure to address the determinants of health
- **build capacity** for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy
- **regulate and legislate** to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people
- **partner and build alliances** with public, private, nongovernmental and international organizations and civil society to create sustainable actions.

**Key commitments**

The four key commitments of the Bangkok Charter are to make the promotion of health:

1. Make the promotion of health central to the global development agenda
2. a core responsibility for all of government
3. a key focus of communities and civil society
4. a requirement for good corporate practice.

**1. Make the promotion of health central to the global development agenda**

The Bangkok Charter advises that strong intergovernmental agreements that increase health and collective health security are needed. Government and international bodies

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\(^{30}\) World Health Organisation (1986), Ottawa Charter for Health Promotion
must act to close the health gap between rich and poor. Effective mechanisms for global governance for health are required to address all the harmful effects of trade, products, services, and marketing strategies.

Health promotion must become an integral part of domestic and foreign policy and international relations, including in situations of war and conflict. This requires actions to promote dialogue and cooperation among nation states, civil society, and the private sector. These efforts can build on the example of existing treaties such as the World Health Organization Framework Convention for Tobacco Control.

2. Make the promotion of health a core responsibility for all of government

The Bangkok Charter also urges all governments at all levels to tackle poor health and inequalities as a matter of urgency because health is a major determinant of socioeconomic and political development. Local, regional and national governments must:

- give priority to investments in health, within and outside the health sector
- provide sustainable financing for health promotion.

To ensure this, all levels of government should make the health consequences of policies and legislation explicit, using tools such as equity-focused health impact assessment.\(^\text{31}\)

3. Make the promotion of health a key focus of communities and civil society

Communities and civil society often lead in initiating, shaping and undertaking health promotion. The Bangkok Charter recognises that they need to have the rights, resources and opportunities to enable their contributions to be amplified and sustained. In less developed communities, support for capacity building is particularly important.

Well organised and empowered communities are highly effective in determining their own health, and are capable of making governments and the private sector accountable for the health consequences of their policies and practices.

The Bangkok Charter considers that civil society needs to exercise its power in the marketplace by giving preference to the goods, services and shares of companies that exemplify corporate social responsibility. It notes that grass-roots community projects, civil society groups and women’s organisations have all demonstrated their effectiveness in health promotion, and provide models of practice for others to follow. Health professional associations have a special contribution to make.

4. Make the promotion of health a requirement for good corporate practice

\(^{31}\) In New Zealand in 2005 the Public Health Advisory Committee (PHAC) produced ‘A Guide to Health Impact Assessment: A Policy Tool for New Zealand’ to introduce health impact assessment (HIA) as a practical way to ensure that health and wellbeing are considered when policy is being developed in all sectors. Refer: http://www.phac.health.govt.nz/moh.ns/insertcm/phac-guide-hia-2nd
The Bangkok Charter recognises that the corporate sector has a direct impact on the health of people and on the determinants of health through its influence on:

- local settings
- national cultures
- environments, and
- wealth distribution.

The private sector, like other employers and the informal sector, has a responsibility to ensure health and safety in the workplace, and to promote the health and well-being of their employees, their families and communities. The private sector can also contribute to lessening wider global health impacts, such as those associated with global environmental change by complying with local national and international regulations and agreements that promote and protect health. Ethical and responsible business practices and fair trade exemplify the type of business practice that should be supported by consumers and civil society, and by government incentives and regulations.

Call for action

Conference participants requested the World Health Organization and its Member States, in collaboration with others, to allocate resources for health promotion, initiate plans of action and monitor performance through appropriate indicators and targets, and to report on progress at regular intervals. This would better enable the health promotion implementation gap to be closed. United Nations organizations were are also asked to explore the benefits of developing a Global Treaty for Health.

3. WHO Commission on Social Determinants of Health

The most recent international landmark publication on action to improve public health is the 2008 report of the WHO Commission on Social Determinants of Health, entitled ‘Closing the gap in a generation: health equity through action on the social determinants of health’.

The Commission - constituting 19 international experts with a blend of political, academic and advocacy experience- spent three years gathering and evaluating evidence on the significant inequities to health existing between and within countries. Their objective was to determine what causes health inequities and what needs to be done by whom if the health of different groups is to be made equal.

The Commission found that social injustice is killing people on a grand scale. They concluded that the poor health of the poor, the social gradient of health within countries, and the marked health inequities between countries are caused by:

- the unequal distribution of power, income, goods and services, globally and nationally
• the consequent unfairness in their access to health care, schools and education, their conditions of work and leisure, their homes, communities, towns, or cities - that significantly diminish the chances of the poor and ill leading a flourishing life.

The Commission concluded that this unequal experience of health-damaging experiences is not in any sense a ‘natural’ phenomena, but the result of a toxic combination of poor social policies and programme, unfair economic arrangements, and bad politics. Together the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries. The Commission calls for closing the health gap in a generation – an aspiration that they believe is achievable if we use the knowledge that exists to make the huge and achievable differences in people's life chances that will result in marked improvements in health equity.

Dame Silvia Cartwright describes the report as being “a decisive tool for all who have an interest in improving the health of the general population, as well as those who are just coming to terms with the importance of this issue for the social and economic wellbeing of the community.”

PHANZ believes that the Commission’s diagnosis is just as relevant to New Zealand as to other countries. Here as elsewhere in the world, factors like housing, education and income contribute to a person’s health, just as much as their physical makeup or behaviour. The opportunity to have a healthy life is not equal across all New Zealanders; it is still linked to social and economic circumstances, in particular childhood deprivation. This means many Maori and other New Zealanders have poorer health, reduced quality of life and early death.

The Commission makes three over-arching recommendations or principles of action to form the basis of a coherent approach to reducing inequalities:

• Improve daily living conditions - the circumstances in which people are born, grow, live and work

• Tackle the inequitable distribution of power, money and resources

• Measure and understand the problems and assess the impact of our actions.

**Improving Daily Living Conditions**

The key areas that the Commission challenges civil society, governments and global institutions to take action on to reduce health inequities by improving daily living conditions are:

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• **Investing in equity in the early years** - laying a critical foundation for the entire life course via: adequately nourished mothers; a continuum of care for mothers and children through pregnancy and childbirth to the early days and years of life; children having safe, healthy, supporting, nurturing, caring and responsive living environments; pre-school educational programmes and schools that build children’s capabilities, build on existing child survival programmes and include social/emotional and language/cognitive development; and providing quality compulsory primary and secondary education for all boys and girls, regardless of ability to pay (including identifying and addressing the barriers to staying at school).

• **Healthy places, healthy people** - developing communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being and that are protective of the natural environment are essential for health equity. This can be achieved through: managing urban development to ensure greater availability of affordable housing; ensuring all households have water, sanitation, electricity and paved streets regardless of ability to pay; urban planning that promotes healthy and safe behaviours; investing in active transport; retail planning to manage access to unhealthy foods; good environmental design and regulatory controls (like controlling the number of alcohol outlets); investing in rural development to reduce rural poverty, landlessness and displacement of people from their homes.

• **Fair employment and decent working conditions** – achieved via making full and fair employment and decent working conditions a central goal of national and international social and economic policy making; providing quality work for men and women with a living wage that takes into account the real and current cost of healthy living; implementing core labour standards, developing policies to ensure a balanced work-home life and to reduce the negative effects of insecurity amongst those with precarious work arrangements; and reducing workers exposure to material hazards, work-related stress and health-damaging behaviours. These things will not only reduce health inequalities but also improve productivity.

• **Social protection across the life course** – governments building universal comprehensive social protections systems that allow a healthy standard of living below which no-one should fall due to circumstances beyond his or her control – and that include those normally excluded (those in precarious work, including informal work and household care or work).

• **Universal health care** – building health care systems based on principles of equity, disease prevention, and health promotion, via: universal coverage, focusing on primary health care; more equitable health-care financing that ensures universal access regardless of ability to pay; investing in national health workforces, balancing rural and urban health-worker density; expanding
capabilities to act on the social determinants of health; redressing the health brain drain by investing in increased health human resources and training, and bilateral agreements that regulate gains and losses.

_Tackling the Inequitable Distribution of Power, Money and Resources_

To address the underlying inequities that cause inequitable conditions of daily living and health inequities, the Commission challenges us to address inequities in the way society is organised. They see this as requiring:

- **Health equity in all policies, systems and programmes** - placing responsibility for action on health and health equity at the highest level of government and ensuring its coherent consideration across all policies; and adopting a social determinants framework across the policy and programmatic functions of the Ministry of Health and strengthening its stewardship role in supporting a social determinants approach across government.

- **Fair financing** – via strengthening public finance for action on the social determinants of health by building national capacity for progressive taxation; increasing international finance for health equity and coordinating increased finance through a social determinants of health action programme; establishing mechanisms to finance cross-government action on social determinants on health, and fairly allocating government resources for action on the social determinants of health between geographical regions and social groups.

- **Market responsibility** – ensure that markets do not generate negative conditions for health equity via: institutionalising consideration of health and health equity impacts in national and international economic agreements and policy-making; and reinforcing the primary role of the state in the provision of basic services (such as water and sanitation) and the regulation of goods and services with a major impact on health (such as tobacco, alcohol and food).

- **Gender equity** – governments, international organisations, donors and civil society can empower women and improve the lives of millions of girls and women and their families by reducing unfair gender inequities, via: addressing gender biases in the structures of society, in the way organisations are run and interventions designed, and the way in which a country’s economic performance is measured; developing and financing policies and programmes that close gender gaps in education and skills and that support female labour force participation; and increase investment in sexual and reproductive health services and programmes, building to universal suffrage and rights.

- **Political empowerment, inclusion and voice** – being included in the society in which one lives is vital to the material, psychosocial and political empowerment that underpins social well-being and equitable health. This can be achieved via: strengthening political and legal systems to protect human rights, assure legal
identity and support the needs and claims of marginalized groups, particularly indigenous peoples; ensuring the fair representation and participation of individuals and communities in health decision-making as an integral feature of the right to health; and enabling civil society to organise and act in a manner that promotes and realises the political and social rights affecting health equity.

- **Good global governance** – via making health equity a global development goal for the UN through WHO; institutionalising social determinants of health as a guiding principle across WHO departments and country programmes to strengthen multi-lateral action on development, with initial working groups on early childhood development, gender equity, employment and working conditions, health care systems and participatory documentary

**Measuring and Understanding the Problem and Assessing the Impact of Action**

The Commission sees acknowledging that there is a problem, and ensuring that health inequity is measured – within countries and globally – is a vital platform for action. This requires national governments and international organisations, supported by WHO to:

- **Set up national and global health equity surveillance systems** – for routine monitoring of health inequity and the social determinants of health and for evaluating the health equity impact of policy and action

- **Create organisational space and capacity to act effectively on health inequities** – by investing in training of policy makers, planners, health practitioners and other stakeholders in the social determinants of health and the use of health equity impact assessment; developing public understanding of social determinants of health; creating a dedicated budget for generating and globally sharing evidence; and moving beyond a biomedical focus in health research to incorporate public health research with strong focus on social determinants of health.