National Council of
Women of New Zealand
Te Kaunihera
Wahine O Aotearoa

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Submission to the Health Select Committee on the
New Zealand Public Health and Disability Bill

Introduction

The National Council of Women of New Zealand (NCWNZ) is an umbrella organisation representing 46 nationally organised societies. It has 35 branches spread throughout the country to which women from some 150 societies are affiliated.

Responses were received on this bill from members of the Health Standing committee, from Branches and from individual members.

NCWNZ has advocated strongly in all areas of health and disability, with policy mandated by the membership over a long period of time.

We support the principles of greater community involvement, greater transparency and openness, meetings open to the public and consultations over strategic plans and the removal of the competitive element in public health administration. We also support the principle that Maori need to participate in both planning and providing services to improve Maori health. However we are aware that involvement of community and Maori will come at a cost, and the benefit of this involvement will have to be monitored against these costs.

We question whether 21 District Health Boards is too many for efficiency. If this number is used we urge that every encouragement be given for them to collaborate as much as possible within geographical locations. The cost of restructuring is high and is not measured merely in financials terms.

The DHBs envisaged seem to be harking back to the Area Health Boards, where the three-yearly election cycle engendered a lack of continuity of care regimes unless the control went to the administrators who had much more knowledge than the lay people elected. There needs to be balance between the need for building large hospitals and providing services and facilities in local communities.

Specific comments

Part 1. Preliminary provisions

Clause 3 Purpose (d) and Clause 4 Treaty of Waitangi

Concern was expressed that the use of the word ‘interpreted’ could make this Act unworkable as it may allow every provision to be given a different interpretation.

Clause 6 Interpretation

The list of definitions should include ‘mana whenua’ and ‘in good faith’.

Part 2 Responsibilities of Minister

Clause 11 National advisory committee on kinds and priorities of services

It is not clear from this Clause if the intention is for this body to replace the existing National Health Committee. If the National Health Committee is to be retained then there needs to be clauses that identify how the NHC would interface with District Health Boards.

Clause 12 Health workforce advisory committee

We agree with the inclusion of Clause 12. We suggest that its first priorities include investigating the recommendations on maternity services, and workforce planning.

Clause 13 National advisory committee on health and disability support services ethics

NCWNZ advocated in 1992 for a national ethics committee to look at biotechnology (That NCWNZ urge the establishment of a national ethics committee to set standards for all biotechnical research and that these standards be open to public scrutiny). We have concerns about the level of independence and consumer input of the Health Research Council ethics committee. Any truly national ethics committee should have to call for public submissions, whereas the HRC ethics committee refers to consulting the public as appropriate. Also, lay membership of the HRC ethics committee does not comply with the national standard for ethics committees. Where a local ethics committee was effectively operating, concern was expressed that this would be replaced by a national body.

Clause 14 Mortality review committees

NCWNZ policy states from 1997 "That NCWNZ lobby for the establishment of an adequately resourced comprehensive child mortality review system to investigate causal and contributory factors that lead to the death of a child". We therefore strongly support the inclusion of this clause.

Part 3 District Health Boards

Clause 17 Objectives of DHBs

Some concerns were expressed that there might be a high level of fragmentation even though the rationale is that there will be less fragmentation with the DHBs managing the total health budget and not just that of the hospitals. It is to be hoped that each DHB will not have a separate ethics committee as it was considered that many areas would not have sufficient throughput for committee members to build up any expertise.

Clause 18 Functions of DHBs

For a DHB 'to ensure the provision of services for its resident population' (18(1)(a)) it will need to understand its population in much the same way as the Regional Health Authorities had to. To undertake such demographic study is a costly exercise, yet if it is not undertaken how would the DHB acquire the information about its constituency?

Clause 19 Co-operative agreements

Members agreed with this clause.

Clause 20 Service agreements

NCWNZ strongly agrees that DHBs should monitor contracts (20(3)) but raised concerns at the level of administrative staff that would be required for this.

Clause 22 Duties of board members

Members queried whether the appointees would have the skills to perform these functions.

Clause 25 Membership of boards

The intention to appoint Maori proportionately to the local population was particularly noted by some members who responded. Members suggested that geographic spread should be taken into consideration when selecting members on the boards. This was as important as the skill mix and ethnicity, and particularly relevant where an area has a widely spread population, or where there was a city plus an outlying rural area.

Clause 26 Crown monitors to sit on boards

The role of the Crown Monitor (26(2)) was seen to be a very powerful role. It was felt that it should be more clearly spelled out whether the Crown Monitor would be regular feature of DHB meetings or an occasional attendee. Concern was also expressed about how the role of the Crown Monitor impacted on the independence of the DHB.

Clause 28 Minister may give directions

Concern was again expressed about the independence of the DHB.

Clause 30 Health improvement advisory committees
Clause 31 Disability support advisory committees
Clause 32 Hospital governance advisory committees

Many concerns were raised about these committees. Specific questions were asked about the size of the committees, eligibility for these committees, whether there would be general public representation on each committee, what the terms of reference were, whether there would be payment for committee members, and whether members would be paid employees of Crown institutions. Also queried were the number of Board members sitting on each committee, and how many committees each board member could be on. Neither the size nor the status of the committees is indicated. The function of the Health improvement advisory committees seems to be very similar to the function of the DHB itself and concerns were raised about the independence of this committee. It is to be hoped that the committees are worthwhile, cost effective and that their reports and recommendations will be implemented and not merely shelved.

Clause 34 District strategic plans

NCWNZ applauds the direction that copies of the district strategic plan must be made available to the general public (34(6)). Presumably this does not mean merely putting it on the web. NCWNZ seeks reassurance that the resident population will be able to comment on the strategic plan in much the same way as the public is able to comment on a Council's District Plan. Some rural members were cynical about the value of consultation, given their experiences of past consultations where services were lost from the community, hospitals closed and no consideration appeared to have been given to the matters raised during the consultation.

Clause 35 District annual plans

It would appear that the general public is to have no access to annual plans until the Minister has signed them. The process of consulting implemented by local authorities should be considered for annual plans.

Part 4 Other public health organisations

Pharmaceutical Management Agency

Clause 42 Objectives of Pharmac

The definition of 'eligible people' 42(a) is not clear. For example, does this mean that overstayers by the nature of being illegal residents do not qualify for pharmaceuticals?

Other provisions

Clause 60 Pharmac, NZNS, and RHMU to operate in financially responsible manner.

Concerns were expressed here over the words 'maintain its long term financial viability' 60(a).

Part 5 Miscellaneous provisions

Inquiries

Clause 65 Inquiries

Members were concerned that the general public should have the ability to make submissions in person to any inquiry. Particularly, they queried whether the public would have to apply for interested party status in order to be heard.

Clause 67 Establishment and alteration of inquiry

Should the Minister take action under 67(1), NCWNZ members believe that a public statement should be made by the Minister stating why these changes were made. Concern was expressed that there be clear criteria for the Minister to follow when using directive power as outlined in 67(2).

Other provisions

Clause 82 No compensation for loss of office

NCWNZ approves the inclusion of this Clause.

Part 6 Transitional and consequential provisions

Clause 84 Interpretation

Clause 85 Health Funding Authority dissolved and assets and liabilities vested in the Crown

Clause 86 Hospital and health services dissolved and assets and liabilities vested in DHBs

Clause 87 Assets and liabilities of New Zealand Blood Service Limited vested in NZBS

Clause 88 Former directors of New Zealand Blood Service Limited to be transitional members of NZBS

Clause 89 Pharmaceutical Management Agency Limited dissolved and assets and liabilities vested in Pharmac

Concern was expressed that the government might be changing the rules retrospectively and affecting redundancy entitlements where someone is not re-employed. Some members indicated that local communities might like to have some input into the final decisions about the disposal of assets. An example given was the case of the Napier Hospital buildings and land, where there is a Waitangi Tribunal claim on the land as it was given for the purpose of providing health services for Maori and others.

Schedule 4 Provisions applying to health improvement advisory committees, disability support advisory committees, and hospital governance advisory committees

General concern was expressed about the advisory committees. The members of these committees will need to understand their populations before they can advise on services. In all areas there will be people who need tertiary levels services (ie cardiac thoracic services) but it is surely not expected that all 21 Health Improvement Advisory Committees will want to establish a cardiac thoracic unit in their area. There does not appear to be provision for members of the public to be represented on these committees.

Conclusion

It was felt that there was not sufficient emphasis on community in the Bill. DHBs have no guidelines advising them how they will consult and work with their communities. DHB plans were required to show that communities had been consulted and many comments were built around the fact that communities are often unaware of consultation having taken place. Consultation needs to be much more open and transparent.

Again, we would like to comment that there are concerns, especially in rural communities, on the amount of change occurring within the health services, but little concrete reason demonstrated as to why those changes are necessary.

Thank you for the opportunity to comment on this very important Bill and we look forward to reading the final version

Barbara Glenie
National President

Elizabeth Bang
Convener, Health Standing Committee