PROJECT ON WAYS TO INVOLVE THE PUBLIC IN THE HEALTH SYSTEM

A report by McKinlay Douglas Ltd
for the Central Regional Health Authority

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EXECUTIVE SUMMARY

The Brief

1. The purpose of this report is to contribute to a project initiated by the Central Regional Health Authority on ways to involve the public in the health system. A key element in our brief was to address the issue of public confidence which was seen to require:

   - Developing processes which give the public an assurance that their voice has been heard at the point of decision making;
   - Allowing the public to understand the need for trade-offs in resource allocation and have a sense that these judgements are being made with an awareness of community concerns;
   - Dealing with the problem that consultation in a legal compliance sense fails to satisfy the public demand for involvement before firm proposals have been developed;
   - Designing structural arrangements which answer the demand for representation without compromising the need for governance.

2. This report has sought to provide a broad overview of public involvement in service planning and delivery within the New Zealand health system, as seen through the experience of the Central Regional Health Authority, supplemented by a brief account of changes in the New Zealand health system since the early 1980s; a look at a broadly parallel New Zealand process, consultation by local authorities; and a review of overseas experience with a particular focus on well known initiatives such as the citizens' or customer charter.

3. The report has recognised that we are looking at a system which is still very much in a state of evolution.

The Context

4. Public involvement in the provision of health services in New Zealand, pre-health reform, concentrated mainly on Area Health Boards. As substantially elected bodies they had a measure of public confidence because of their apparent representativeness and their relative ability to fund most community health concerns.

5. The reforms begun in the late 1980s brought an explicit recognition of the need for something different: expert rather than elected governance and professional management but with a role for community input and better understanding of community preferences and priorities. It is evident that there have, however, been

different expectations about what 'community input' might mean within the community at large on the one hand, and on the part of Ministers and officials on the other.

6. In tandem with the community interest emphasis in the health reforms have gone measures intended to restrain overall expenditure and improve the efficiency of resource allocation, regarded as appropriate matters for public consultation but bound to heighten public concerns about access to health services.

7. On the part of successive governments, greater public involvement has been seen as a necessary component in securing public acceptance of restraint and reform. The separation of purchase and provision has carried with it the notion of RHAs as agents of their communities, purchasing on behalf of and therefore accountable to, the persons/community receiving the service. In addition, community input is now being seen as an integral part of services planning. On the public's part, however, many people do not understand and/or are confused about the purpose and objectives of the health reforms. There is a manifest unease about the fairness of resource allocation and the quality of health service delivery. Alongside this has gone an increasing demand for and expectation of opportunity for more public debate and influence on health service decision-making.

The Experience

8. In practice, most of the effort the RHAs have put into community input has been through formal consultation, and within consultation most attention has been on provider consultation and the contracting relationship. Consultation at the 'micro' level of individual services has been more successful than consultation at the 'macro' level of strategic directions in purchasing. Other than these, within the CRHA no clear pattern of consultation activity is apparent from past experience. This is an understandable by-product of the nature of the health reforms, and can be seen as characterising a stage in the evolution towards wider public involvement, and different forms of involvement of which consultation is but one component.

9. The CRHA has however profited from its consultation 'learning curve' over the past four years. Together with advancements in the thinking on public involvement, the lessons of past experience are encouraging the RHAs, CRHA included, to look for more effective ways to establish their community relationships and enhance consultation processes for purchase planning, service planning and service development.

Why Public Involvement?

10. The rationale for public involvement can be divided into two broad categories: operational (that is, reasons that have to do with the functioning and management of the health system); and strategic (reasons that arise from the relationship between how society or a community works, and the ability to achieve good government). A

further rationale can be considered: the contribution which public involvement can make to the management of fiscal risk.

11. The *operational* argument for public involvement is grounded not in the issues of appropriate incentives, role conflict and accountability, but rather in the issues of understanding and responsiveness to community values and preferences. The 1991 Green and White Paper stated "there must be a clear distinction between those moral issues into which the community must have an input, for instance defining 'core' services, and those management issues which are less amenable to public consultation, and are best left to those who are expert in the area."

12. The *strategic* argument for public involvement is most usefully explored by looking at the international debate on the relationship between social capital and civil society, and the capacity for effective government; and by looking also at recent work on the role of 'trust' in reducing transaction costs in society and building confidence in the legitimacy of institutional performance. 'Social capital' refers to features of social organisation such as networks, norms and social trust that facilitate co-ordination and co-operation for mutual benefit. 'Civil society' refers broadly to both formal and informal social engagement, or interaction, among individuals and groups which takes place in a domain that is neither purely individual, nor commercial nor governmental. The 'trust' concept comes from the thesis that the rational economic model is incontestable, but it cannot function without a healthy civil society. In the public domain, this includes a trust-based approach to the dealings between institutions and the citizens they serve. Trust and rules are inversely related. Lack of trust imposes a kind of tax on economic activity which high-trust societies do not have to pay.

In the social capital/civil society debate, while the direction of cause-and-effect is still under examination, the consistent themes are:

- The strength of social capital and civil society as factors in the willingness of individuals or groups to accept government actions as legitimate (even when particular actions such as rationing social services run counter to their own interests);

- the potential for the conduct of governments and public institutions to undermine social capital and civil society and hence the legitimacy of government itself but equally the potential to reinforce that legitimacy.

The application of the 'trust' concept to the role of government seems obvious, especially when governments are faced with inherently subjective and complex decisions such as in the allocation of health resources. Low trust implies not only high transaction costs but also lack of legitimacy and therefore increased pressure from special interest groups and from society at large, to force change outside the

boundaries set by government and its institutions. Recognition of the benefits of a trust-based approach to relationships is growing in the commercial sector, overseas and in New Zealand.

13. The three concepts of social capital, civil society and trust provide some sensible guidelines for building relationships that minimise risks to public confidence and the level of trust in the legitimacy of institutions and the processes they follow, especially when the public does not have the choice of exit. Significant change is however required to move to an environment where these ideas can be adopted and made to work.

14. From a *fiscal risk* perspective, health is probably the most difficult policy area for any government. Public concern at perceived under-performance seems almost always reflected in a demand for more money, regardless of whether that is really the issue.

It is difficult to prove beyond doubt that there is a direct linkage between the level of public confidence in the health system and the demand for additional expenditure for its own sake, especially when the situation is complicated by the demands of an ageing population and increasing technical possibilities in health treatment, and by the unclear relationship between additional funding and additional delivery.

Nonetheless, prudent management should assume such a linkage exists and place a high priority on building and maintaining public confidence in the way in which resources are allocated and priorities set. Furthermore, to this end, the focus of public consultation would ideally shift from consultation on specific services, to consultation on how to obtain maximum health gain for the community overall, from a given level of resources. This may be a difficult shift to make, but the magnitudes of expenditure on health are such that substantial investment in public involvement can be justified simply as a fundamental element of risk management.

Options for Public Involvement: New Zealand and International Experience

15. Enhanced public involvement and user influence has been gaining ground as a significant theme in major reforms in government services internationally over the last decade. Both in New Zealand and overseas, especially in OECD countries, various forms of public involvement have been seen as a component of better quality government, and hence of quality of outcomes, at two levels: improved policy and decision-making; and improved service delivery. Approaches to, and methods of, public involvement are diverse, but certain common themes are apparent:

- recognition that not all government reforms, in themselves, lead automatically to enhanced public accountability or to effective programme outcomes;
- increasing recognition of the importance of the distinction between *choice* and *voice* for users of services;

- the concept of 'customer focus', borrowed from the private sector, as a driver of management style;
- a shift towards public/user involvement as a contributor to the achievement of strategic and organisational objectives, in contrast to the past and still current focus on compliance-driven consultation.

16. It would be fair to say that the expectation world-wide is improvement, not perfection. That sets a realistic goal for learning from wider experience with public involvement in New Zealand, and from international models.

17. Section 7.1 of this report surveys a broad spectrum of ways in which governments in New Zealand and elsewhere have gone about seeking public and user input to policy and the planning and development of social services, and comments on their relevance and success. It presents these in the four categories shown in the following table which broadly scales the different forms of public involvement according to degree of involvement, and going some way to matching the objective of public involvement with the choice of mechanism.

Routes to Public Involvement in Service Planning and Delivery

Information (right to know and influence)	**Consultation (statutory, discretionary)**
Citizens' charters Published quality standards	Voice (public meetings, submission processes etc) Citizens' juries Complaints and advocacy procedures Commissioners
Participation (expectation of community influence)	**Decision-making (partnership, democracy)**
Community customer advisory boards Service advocacy Citizens' referenda (non-binding) Citizens' parliament Technical rationing with public input Pluralistic bargaining/consensus	Direct representation (elected membership, other) Citizens' referenda (binding) Community planning/delivery models

18. The major themes that emerge from this survey are:

- Some approaches, for example the citizens' charter, have more to do with customer service than community values and preferences and are therefore most immediately relevant to service providers. But they can be inferred to be

important to government purchase agencies because of their role in building public confidence in service fairness and quality; and they can readily be adopted by purchase agencies themselves to govern their own relationships with community and consumer interests. The particularly relevant feature of these approaches is that because they bring attention to service and organisational performance, they are necessarily about working for and earning confidence;

- The insights that can be drawn from how central government and local government respectively have approached their publics. There is very considerable scope for each sector to learn from the other. In New Zealand, experience with consultation has taken local government further than central government in terms of learning what works best, and thinking beyond formal consultation on published proposals and plans to a growing acceptance of the need to distinguish between 'compliance' consultation and effective communication. This is evident in examples given in paragraph 7.1.11 of how three local authorities in New Zealand have gone about consultation;

- 'Consultation' is often equated with public/community and user participation. Consideration of the full spectrum of ways to involve the public emphasises that they are not the same, and may sometimes be associated with fundamentally different mindsets, expectations and outcomes;

- Some approaches make best sense when used in conjunction with another. Examples are the citizens' charter which typically has complaints procedures as a major part of the overall design; and the natural linkage between complaints procedures and advocacy services set up to support complainants;

- Key issues for the effective operation of groups (as compared with processes) set up to provide an avenue for community and user input are their powers and capacity, particularly the power to hold the decision-making authority to account and the adequacy of their resourcing. Community advisory boards are a classic example where these issues are crucial;

- The most effective way to address concerns about people's access to decision-makers may well to be found in local government, at least in New Zealand. There is evidence of a distinct shift of focus towards the local authority as the body with the responsibility to represent the interests of its community to central government as the social service provider. This process can be expected to evolve. Local authorities are recognising, increasingly, that their role is shifting beyond the conventional one of core infrastructural services and local recreation and cultural facilities towards one which more resembles that of governing the locality. A strong interest in quality of life is a natural corollary. The potential for such a role has recently been recognised by the Prime Minister.

- Experience with processes for the setting of health funding priorities has, world-wide, been that whatever process is adopted, the final outcome is the same - the 'big' questions of 'what services' and 'what access' remain;

- The question of ‘who decides’ which interests (groups and individuals) should be involved in any public, community or user process arises for nearly all the different approaches that can be taken;

- The key nexus in the accountability relationship of elected bodies to those who elect them is that the resources these bodies control are provided by those who elect them. It is this that provides the incentive to manage resources effectively and efficiently;

- Giving communities and users of services real roles in social service decision-making (planning and delivery) will sometimes best be achieved through partnership approaches which bring central government together with community groups, interest groups, local authorities and other public authorities. As well as improving the co-ordination of programmes, genuine partnership approaches facilitate the development of new initiatives that address service gaps in the community. Initiatives of these kinds are already being developed in New Zealand, drawing on overseas models. Examples are the Healthy Cities and the Safer Community Councils initiatives.

Options for Public Involvement: Options for Use in New Zealand’s Health Sector

19. Section 7.2 of this report draws out options we believe are realistic ways to advance the CRHA’s public involvement objectives.

20. In our view, the issue of public confidence is not so much a matter of the selection of the specific means to be followed in any given case so much as the underlying structural and organisational context (including the culture of the organisation) in which consultation takes place. This implies a number of pre-conditions. Selection of a potentially ideal means of consultation is unlikely to lead to a good outcome if:

    - There is a mis-match between external and internal processes (for example the organisation fails to respond in a timely and understanding way to written or oral submissions);
    - There is an absence of commitment within the organisation so that there is no follow-through;
    - Internal co-ordination is lacking so that the public or other parties consulted receive mixed messages.

21. The five options selected are:

- The customer charter;
- Customer advisory boards;
- The Statement of Intent;
- Local government involvement;
- Elected boards.

Consistent with the four major objectives we were asked to address, as set out in paragraph 1.2 of our report and at the beginning of this summary, we focused on 'macro' level tools which have the purpose of helping create an environment to:

- enhance the likelihood of selecting the measures which best suit any particular initiative to involve public/users;

- build public confidence that those measures will produce outcomes which, even if unpalatable, can be seen as "fair" in the sense of being the product of a legitimate process.

22. Correlated to this are the three lines of inquiry on social capital, civil society and good government which are coming together in a broad-based debate with valuable implications for policy-makers and politicians. Of specific interest for the purposes of this report is whether the debate raises issues which should be taken into account in structuring and managing the relationship between the CRHA and the communities it serves. We believe the answer is yes, and endorse the view of Professor Robert Putnam, a leading exponent of social capital and civil society, that what is needed is a thorough, empirically grounded debate about how to revitalise civic engagement. Putnam cites neighbourhood crimewatch groups as an almost unique example in modern America, of a government initiative which has specifically recognised the contribution which the strength of community interaction can provide to dealing with a public policy issue. There is an obvious parallel in New Zealand with Safer Community Councils and the initiatives which they have supported.

Conclusions

23. We conclude that the combination of a customer charter, a customer advisory board, and a partnership with local government in facilitating community based advocacy offers the best prospect for a structure for public involvement which will be effective both to rebuild public confidence and provide the means of gaining public understanding of the constraints under which a health system must necessarily operate. We see this as underpinned by appropriate provisions in the relevant Statements of Intent.

24. All of these proposals are structural in nature. We have taken the view that the circumstances in which the New Zealand health system now finds itself needs a structural/organisational approach to facilitating public involvement and that, if this can be achieved, then the question of which means of consultation/involvement to use on which occasion will prove comparatively simple to resolve. If however the structural issues are not addressed, then we believe that no specific means for consultation/involvement, regardless of how theoretically ideal it may be, will be effective to build and maintain the public confidence which is a precondition to an effective, efficient and legitimate health system.

25. Finally, although we have canvassed the possibility of an elected component within either Regional Health and Community Services or within the proposed national funding agency or its regional offices, we are not enthusiastic about this. Direct election to the governing body (whether to produce a minority or a majority elected membership) we see as contributing neither to genuine public involvement nor to the maintenance of fiscal discipline. With caveats, we suggest the alternative of an elected accountability board.

1.0 INTRODUCTION

1.1 McKinlay Douglas Limited ("MDL") was invited by the Central Regional Health Authority ("CRHA") to contribute to a project on ways to involve the public in the health system with project tasks and method, respectively, defined as:

Task:

- Consider cost effective ways to assess consumer preferences (surveys, focus groups, etc);
- Consider cost effective ways to involve the public in service planning and monitoring;
- Review the legal requirements to consult and consider whether these can be improved.

Method:

- Consider the feasibility and effectiveness of using various methods to determine consumer preferences, e.g., utilisation data, surveys of consumers, surveys of the public, focus groups with consumers, focus groups with the public, community health committees, complaint systems, advocacy systems, etc;
- Consider ways to involve the public in service planning and monitoring, including:
  - ⇒ service development groups and community health committee system used by some Area Health Boards;
  - ⇒ community health groups used by some RHAs;
  - ⇒ methods used by territorial local authorities;
  - ⇒ any useful overseas models;
- Review the legal requirements to consult and consider whether these can be improved.

MDL, in its response to the invitation, emphasised the issue of public trust or confidence and noted that this was "fundamentally a question of perceived legitimacy of process and structure. In other words, is it the right kind of organisation (in terms of governance, accountability, responsiveness, etc.,) and are the processes which it pursues regarded as 'fair'."

1.2 In summary, MDL proposed that addressing the public confidence issue required:

- Developing processes which give the public an assurance that their voice has been heard at the point of decision making;
- Allowing the public to understand the need for trade-offs in resource allocation and have a sense that these judgements are being made with an awareness of community concerns;

- Dealing with the problem that consultation in a legal compliance sense fails to satisfy the public demand for involvement before firm proposals have been developed;
- Designing structural arrangements which answer the demand for representation without compromising the need for governance.

1.3 MDL also suggested that the second component in the project, the feasibility and effectiveness of using various methods to determine consumer preferences, be seen as a second order issue with specialist input being contracted from a separate party if required.

1.4 The MDL response was accepted by the CRHA.

ABBREVIATIONS USED IN THIS REPORT

CAB	Consumer Advisory Board
CHE(S)	Crown Health Enterprise(s)
CHG(s)	Community Health Group(s)
CRHA	Central Regional Health Authority
Green and White Paper	"Your Health and the Public Health", A Statement of Government Health Policy by the Hon Simon Upton, Minister of Health, 1991
MDL	McKinlay Douglas Limited
NHC	National Health Committee (formerly the Core Services Committee, full title now the National Advisory Committee on Health and Disability)
NHS	National Health Services (UK)
RHA(s)	Regional Health Authority(ies)
SOI	Statement of Intent
SRHA	Southern Regional Health Authority

2.0 METHODOLOGY

2.1 The methodology section of MDL's response proposed:

- Review of the experience of the four RHAs in community consultation including the use of community health groups (CRHA) and consultation groups (SRHA) and the methods employed by North Health and Midland RHA;
- Assessing the potential for the emerging role of local authorities as advocates on behalf of their local communities to be used as a validating mechanism for the role of the CRHA and CHEs;
- Review of the developing experience with customer advisory boards and customer charters including the UK Citizens' Charter (we have an association with Diana Goldsworthy of RIPA, in the UK, who played the lead role in developing the citizens' charter proposal for the conservative government);
- A review of developing experience within local government with public consultation and alternatives/supplements to the statutory process under section 716A of the Local Government Act 1974. We will draw on our extensive linkages with the local government sector and on the expertise of one of our senior consultants, Brendon Whiteman, who was previously General Counsel for the Local Government Association;
- Consideration of the scope for using instruments such as your own Statement of Intent, and purchase agreement, and the Statements of Intent and purchase agreements of CHEs for building in processes/requirements with the purpose of raising public confidence;
- Review of the emerging findings from the civil society/social capital work being undertaken primarily in the US and the UK which we are currently accessing as part of a major project being undertaken with the Institute of Policy Studies;
- We will draw on our own extensive experience of governance issues in designing options for a representation component which does not prejudice governance;
- We will undertake a limited literature search looking for domestic or overseas options and will also liaise with overseas connections with expertise in this area including:
  - ⇒ The National Academy of Public Administration in Washington DC (the Federal Government's "in-house" think tank on public administration issues broadly defined);
  - ⇒ The New Economy Development Group in Ottawa, Canada which undertakes major community development/consultation work internationally;
  - ⇒ The Town and Country Planning Association in the United Kingdom which undertakes extensive work on community consultation.

2.2 Part way through the process of discussing methodology with the CRHA, the Transitional Funding Agency (TFA) was formally announced. MDL was advised that "… the situation on consultation is clearer. Consultation with the key health agencies is likely to be conducted through a separate process in the future on a number of issues. As a result, the consultation you wish to engage as part of your work plan should be limited to Central RHA staff".

2.3 We had been intending a comparatively wide range of interviews with people from the health sector, outside the CRHA, and with people from local government, in order to get their perspectives on consultation within the health sector, especially as compared with the practices for consultation which have developed in local government.

2.4 With the changed emphasis of the project, we concentrated on:

- Interviews with CRHA staff;
- Written material, including various reports on the health sector reforms, internal CRHA documents, and material provided to us by some local authorities on their own consultation practices;
- Interviews with selected public officials with knowledge of the governance of Crown owned entities testing the use of instruments such as statements of intent as a means of supporting consultation;
- Interviews with selected health sector officials for the purpose of gathering generic background material, particularly on the requirements, machinery and processes for consultation applied in other government health agencies;
- Discussions with selected individuals from local government seeking generic impressions on the effectiveness of consultation instruments, but without directing their attention specifically to the requirements of this project;
- A limited literature search, especially of overseas material bearing on initiatives such as customer charters and customer advisory boards.

3.0 SCOPE OF PAPER

3.1 The remainder of this paper is divided into the following sections and coverage:

⇒ **Context: The Promise and Reality of Public Involvement**. This section draws on key policy documents, legislation and ministerial statements to demonstrate the basis on which the public could expect significant involvement;

⇒ **Current Situation and Practice**. This will cover the practice of consultation as it has developed within the CRHA.

⇒ **Why Public Involvement?** This section will examine the case for public involvement at two separate levels:

i. what we term the operational level in which we focus on the case for putting in place/enhancing means for public involvement in the New Zealand health system;

ii. What we term the strategic level in which we look at the emerging debate on the relationship between social capital, civil society and good government. The discussion is not specific to the health sector but nonetheless seen as an important component of the project as exploring the context in which governments seek to function and deliver on important social objectives.

Finally, in this section we look at public involvement as a means of managing fiscal risk.

⇒ **Options for Public Involvement**. This section will cover:

i. Domestic and international experience with public involvement/user influence in policy making/service delivery;

ii. Options for use in New Zealand's health sector, which will include discussion of necessary pre-conditions/criteria, as well as of possible structural and other options;

⇒ **Conclusion.**

The last part of this section considers the potential for public involvement as a means of managing fiscal risk.

4.0 CONTEXT: THE PROMISE AND REALITY OF PUBLIC INVOLVEMENT

BACKGROUND

4.1 The policy approach to public involvement in the provision of health services has traditionally been very much a function of concerns about the level of health services expenditure and has concentrated, typically, on services provided by hospitals. There have been several reasons for this, including:

- The proportion of health services expenditure which has gone on hospital based services;
- The relatively generous treatment of hospital based services until the commencement of serious reform in the early 1980s;
- The easy focus which hospitals provided, both as physical entities and as creatures within wholly or partly elected structures (until 1993), for the expression of public concern.

4.2 Through the 1960s and 1970s, Hospital Boards, as they then were, benefited from a very generous approach towards funding. They received full compensation for inflation in wage and salary costs (with some constraint, admittedly, being exercised by centralised control over wage fixing), plus a 1% per annum provision for real growth, plus a funding framework for new capital expenditure which saw both the capital and operating costs of new facilities provided as additional money.

4.3 Under this approach, most Hospital Boards were relatively free from pressure for public involvement. As elected bodies, they had a structure which appeared to be responsive to their local communities and the relative generosity of their funding arrangements meant that most of them were able to deal with most community concerns.

4.4 This system came under increasing pressure from a number of directions, including:

- Growing recognition that the essentially historical base of funding was producing major imbalances as between different regions with the Auckland region, in particular, becoming more and more disadvantaged because of its rapid population growth relative to the rest of the country;
- Recognition, at both a policy advice level and a political level, that it was no longer possible to afford the very generous approach to health sector funding and in particular, hospital funding, characteristic of then existing arrangements;
- Growing concern regarding the structure of Hospital Boards themselves. As they were spending taxpayers' money, rather than monies raised from the local community, it was believed that there was a lack of sufficient constraints to encourage boards to be parsimonious in expenditure or communities to require proper accountability or, for that matter, to take a close interest in the electoral

process in order to ensure that board members were prudent in their use of community resources.

4.5 A series of reforms were introduced intended, initially, to encourage the voluntary transition from Hospital Board to Area Health Board status. Voluntary reform was slow. Although the Area Health Boards Act was passed in 1983, the first Area Health Board (Northland) was not formed until 1 September 1984 and by 1989 only 7 had been created, with 14 of the 29 Hospital Boards still in place. To hasten restructuring the then Minister of Health, the Hon Helen Clark, promoted legislation which completed the restructuring on a compulsory basis.

4.6 Area Health Boards comprised a mix of elected and appointed members. This reflected a concern that the electoral process needed to be balanced by a separate process capable of bringing in people with the financial and management skills required for the governance of large complex organisations. In a speech to the Institute of Health Management on 22 November 1989, explaining the decision to increase the number of appointed members of Area Health Boards, and dispense with the consent of the Boards as a pre-requisite to appointment, the Minister stated:

> *"At the moment 3 members may be appointed, but only with the consent of the Board. The increased number of appointments will provide more flexibility. We will be able to ensure that an appropriate blend of community representation, along with managerial and financial knowledge, is present on each Board."*

4.7 In parallel with, but moving faster than, the restructuring of Hospital Boards into Area Health Boards, government moved away from the old "last year, plus a bit" approach to funding. On 1 April 1984, it introduced a population based funding system intended both to shift resources as between different parts of the country and to restrain overall expenditure, especially within the hospital sector. The Department of Health in " Health Expenditure Trends in New Zealand 1980-1991" notes:

> *"From 1982 to 1991 there was a general decline in institutional care expenditure. Expenditure on institutional care, which accounted for 65.0% of the total in 1982, declined progressively to 56.4% in 1991. The main reason for the general decline was the declining trend of expenditure by the public institutions. In 1982 public institution expenditure was 60.7% of total expenditure on health. This proportion gradually reduced during the last 9 years to 50.9% in 1991. In particular, the latter part of this period was characterised by government funding restraints on Hospital/Area Health Boards."*

THE REFORMS

4.8 We have outlined these changes in some detail as we believe they set the context for a marked change in public acceptance of the legitimacy of decision-making processes within the health system. So long as the principal institutions within the sector were publicly elected, and there was comparatively little restraint on expenditure, there was little basis for significant public concern for a greater say over what was happening. Throughout most of New Zealand, there was enough "slop" and sufficient evidence of on-going investment (new construction, services, etc) to feel that the system was responsive to public need. Diminution of elected input, and then its demise with the 1993 reforms coupled with an emphasis on expenditure restraint, produced a significantly different context.

4.9 In the first wave of reform, in the late 1980s, there was explicit recognition of a continuing role for some form of community input. This was seen as requiring something different, both from the input which might come from elected members, and from the views/decisions of individual consumers. In respect of the latter, the then Minister, in rejecting the findings of the Gibbs[1] report, stated:

> *"The individual's knowledge of the health services market can never be complete, and his/her ability to make rational decisions about how much or what type of services they should purchase and plan for can only be minimal."*

However, she put stress on community involvement as an important element in health services planning. In an address to General Managers and Area Health Board representatives on 15 December 1989, on the future direction of the health system, she set out the principles underlying the Labour Government's New Zealand Health Charter. The third was stated as:

> *"There must be community involvement in the planning for provision of health services within the regions so that the service can be responsive and relevant to the community being served."*

This was clearly seen as being something different from the input expected from the elected members, who made up approximately two-thirds of Area Health Board membership.

4.10 Structurally, this can best be seen as reflected in the Area Health Boards' legislation with its provision for Service Development Groups and Community Committees. We say this despite the fact that the legislation itself had been in place for some years. It was mandatory for Service Development Groups but discretionary for Community Committees and applied in varying degrees by different Area Health Boards[2]. Arguably, the principles articulated by the Minister can also be seen as

[1] *Unshackling the Hospitals,* Report of the Hospitals and Related Services Taskforce, Wellington, 1988

[2] Under the legislation:

- Every Area Health Board shall from time to time appoint sufficient service development groups, consisting of two or more persons, to advise the Board, in accordance with any policy directives

reflected in the companion document to the New Zealand Health Charter, "A Contract for Area Health Boards" which stated:

> *"The focus of planning will be expected to be initially on the New Zealand Health Goals and Targets, a companion document to the New Zealand Health Charter, and then on regional goals and targets.*
>
> *"Planning will accordingly need to involve appropriate consultation with the community to ensure that the actual and intended use of public health resources is responsive and relevant to the community being served."*

4.11 The theme of community involvement was carried forward in the rationale for the changes implemented with the passage of the Health and Disability Services Act 1993. The National Government, however, was clearly critical of what had been the main means of public influence over the provision of health services, the interaction between communities and the Area Health Boards which they elected. This was seen as frustrating the ability of Boards to bring about needed change. Thus, the Green and White Paper "Your Health and the Public Health" stated "for example, a Board may develop a strategic plan which it considers is appropriate for the region as a whole. However, announcement of any strategy is sure to bring vehement protests from numerous interest groups, and public campaigns against change. Often this sort of response effectively paralyses Boards' ability to take decisions". In essence, the National Government was saying that relying on elected Boards as a primary means for community input was substantially negative in its effect, as a barrier to change rather than as an incentive to change.

4.12 This was seen as a separate issue from the fact that Area Health Boards were both purchasers and providers, but as one which would benefit from broadly the same approach of separating purchase and provision and putting an emphasis, on the purchase side in particular, on an improved understanding of community preferences and priorities whilst, at the same time, sheltering the more expert or technical decisions on how to meet those needs from the political pressures inherent in the Area Health Board system. This was reflected in further comment in the Green and White Paper:

- prescribed by the Board, on the full range of health services in the public, private, and voluntary sectors relevant to its district. There was nothing in the provision for service development groups which required the members to come from any particular background so that, in practice, they provided an opportunity to create a forum in which to bring together different views, from professionals, from users, and from the wider public.
- Area Health Boards were empowered, from time to time, to appoint a community committee consisting of two or more persons, in respect of any area within its district. The committees were intended to provide a forum for the various community groups working in the health field, and a liaison between such groups and the Board. With the abolition of Area Health Boards, community committees within the district of the CRHA became community health groups.

"The system, however, generally remains centralised, rigid and unresponsive to change. Attempts by Area Health Board management to make strategic decisions which allow greater choice and flexibility in health services inevitably run into resistance from various interest groups which resist the proposed changes. There must be a clear distinction between those moral issues into which the community must have an input, for instance defining "core services", and those management issues which are less amenable to public consultation, and are best left to those who are expert in the area.

"After considering all the alternatives, the government decided that fundamental reform of the system was essential. It decided to move to a system ***which would reflect the choices of groups and individuals about the health services they want, and how they would like these services to be delivered*** [emphasis added]. *The system should allow both users of the health system and health providers to experiment with new styles of health care, particularly appropriate for New Zealand consumers."*

4.13 This theme was reflected in the report of the National Interim Provider Board "Providing Better Health Care for New Zealanders" which stated that "RHAs will be consumer oriented organisations that will use market research and community consultation in addition to their performance review of provider contracts."

4.14 The legislation itself continues the theme of acting on behalf of individuals and communities. The functions of Regional Health Authorities, as stated in Section 33, include:

- To monitor the need for public health services, personal health services, and disability health services of the people who are described for this purpose in its funding agreement;
- To purchase public health services, personal health services and disability services for those people, by means of purchase agreements or otherwise.

This way of expressing the purchase function can be seen as carrying with it the implication of purchasing on behalf of, and therefore being accountable to, the persons/communities receiving the service, rather than on behalf of (say) the Government as part of meeting its commitment for the delivery of services.

4.15 This can be seen as supported by the language of some of the Ministerial speeches of the times. The following are taken from various speeches given by the Hon Katherine O'Regan, Associate Minister of Health:

- "It is the purchaser/provider split which will give birth to the four Regional Health Authorities. They will buy primary and secondary services for their populations from a range of publicly and privately owned providers", speech to the Innovation and Health Care Seminar on 22 February 1992;
- "One of the effects of the reforms is to shift responsibility for services onto the RHAs. They are the ones who are charged with consulting their communities, negotiating the contracts and resolving local issues" and "the reforms are directed towards a consumer orientated services" from an address to the NZ Institute of Health Management, 15 October 1993;
- Speaking of RHAs "and they will be obliged to consult widely with the communities **whose agents they are**, through market research, surveys, and listening to community groups" [emphasis added], from an address to the Dorris Gordon Society, 6 November 1992;

4.16 This interpretation needs some qualification. The long title to the Health and Disability Services Act 1993 itself states its purpose as to reform the public funding and provision of health services and disability services in ways which will "secure for the people of New Zealand (i) the best health; (ii) the best care and support for those in need of services; and (iii) the greatest independence for people with disabilities that is reasonably achievable within the amount of funding provided". This clearly flags accountability to the funder alongside meeting the needs of the people of New Zealand. At the time the legislation was passed, there was an intention that public choice would be increased by the opportunity to migrate from the RHA funded system to a health care plan. For some involved in the reforms, this was seen as being the main way in which the public would, in practice, exercise choice over services.

4.17 In this section we have traced, in some detail, the evolution of government policy, through speeches, policy documents and legislation, regarding the role of the public in health services planning and monitoring. There is a clear pattern leading up to the passage of the Health and Disability Services Act of accepting an increased role for community involvement. What may be less clear is exactly how various parties expected that this role would be expressed. On balance, it seems likely that public expectations raised by the structure of the legislation and, more importantly, various public statements, speeches, etc., may have encouraged an expectation of greater direct public involvement than either Ministers or their advisors anticipated.

4.18 The emphasis on an increased role for community involvement has also gone in tandem with measures intended to restrain overall expenditure within the health sector and improve the efficiency of resource allocation. These objectives, which were central to Government's purpose, fall outside the ambit of what has traditionally been seen as appropriate for public consultation.

4.19 There seems to have been a clear recognition that restraint, and the measures necessary to improve resource allocation, were likely to heighten public concerns about access to health services, especially when compared with the relatively unconstrained approach to health expenditure up until the early 1980s. It is at least arguable, from the material surveyed in this section, that successive governments recognised that greater public involvement was a necessary component in managing public acceptance of restraint and reform.

5.0 CURRENT SITUATION AND PRACTICE

5.1 CONSULTATION UNDER THE HEALTH AND DISABILITY SERVICES ACT 1993

Legislation and its effects

5.1.1 The Health and Disability Services Act 1993 imposes on Regional Health Authorities an obligation to consult. This is stated in Section 34 of the Act as:

> *"Every Regional Health Authority shall, in accordance with its Statement of Intent, on a regular basis consult in regard to its intentions relating to the purchase of services with such of the following as the Authority considers appropriate:*
>
> *(a) individuals and organisations from the communities served by it who receive or provide public health services or personal health services or disability services;*
>
> *(b) other persons, including voluntary agencies, private agencies, departments of state, and territorial authorities."*

5.1.2 The Health and Disability Services Act is only one of several of pieces of legislation which create a statutory duty to consult. The nature of the duty, and how it should be exercised, has been the subject of a number of court cases. The principal case on the requirements for public consultation is the so-called Wellington International Airport case under which Air New Zealand, Qantas and Ansett challenged certain decisions of the airport company in fixing landing charges, arguing that the company had failed properly to "consult" as required by its enabling legislation. In its own protocol and guidelines for consultation, the CRHA summarises the requirements set out in the *Wellington International Airport* case as:

Consultation does not mean negotiation or agreement. It means;

- Setting out a proposal not finally decided upon;
- Adequately informing a party of relevant information upon which the proposal is based;
- Listening to what others have to say with an open mind (in that there is room to be persuaded against the proposal);
- Undertaking that task in a genuine and not cosmetic manner;
- Reaching a decision that may or may not alter the original proposal.

5.1.3 The CRHA's own legal advice adds a number of clarifications to the Wellington Airport case, reflecting both the specific requirements of the Health and Disability Services Act and the varying circumstances applying to the different matters on which the CRHA may be obliged or wish to consult. Amongst the points made are:

- It must consult “on a regular basis” which implies a continuing process rather than one-off meetings whenever a decision is required;
- It has some discretion as to whom it should consult but should only exclude parties when to do so can be shown to be fair and reasonable;
- There is no general definition of consultation. In each case what is required will depend upon the context. Factors such as the seriousness of the matter, especially as regards affected parties, and the timeframe under which the CRHA may be operating (is an urgent decision required?) will both be relevant;
- The requirement to consult “on a regular basis” may mean that consultation should begin at an earlier stage of the decision making process than the discussion of proposals that are intended to be final;
- It is not wrong for the CRHA to have formed a provisional view and in practice this may be necessary before there can be proposals on which to consult;
- The decision maker should be prepared to give reasons for the ultimate decision, and for any decision not to accept the views of consulted parties.

5.1.4 In a March 1996 document “A Review of Community Consultation” the CRHA notes that “since its establishment in July 1993, Central RHA has put a greater emphasis on provider relationships rather than community relationships and consultation with the community has not moved as quickly as provider development. This is understandable, and true of all RHAs, because of the need to establish the machinery of the purchaser/provider split.”

5.1.5 To the extent that the CRHA has sought community involvement through formal consultation under Section 34, the process has involved:

- Documentation of a specific service proposal;
- Release of that proposal for consultation, typically by forwarding it to selected stakeholders (for example, the provider groups most directly involved), advertising its availability through the public notices columns of selected newspapers and forwarding copies to Community Health Groups for comment. Not all proposals have been publicly advertised or forwarded to CHGs.

5.1.6 The same review notes that the principal mechanism for community consultation has been CHGs and the CRHA’s Community Co-ordinators working with them. Recent work reviewing experience with that process has raised serious doubts regarding both the effectiveness of CHGs as the principal provider of community input, and the CRHA’s own commitment to seeing them as an important part of its consultation process.

5.1.7 Consultation in the health sector, broadly defined, can have at least three separate objectives:

- Legal compliance. Ensuring that the CRHA has complied with its statutory obligation "to consult" so as to protect it against legal challenge. This is primarily a matter of taking steps which will satisfy a court, in the context of an application for judicial review, that the CRHA has satisfied its legal obligations;
- Obtaining different or better information so as to improve the quality of the decisions taken by the CRHA and the effectiveness of its purchasing activity to meet health needs;
- Managing public pressures on the health system through securing a better understanding of the constraints under which purchasers operate, including an awareness of limited resources and the need for public acceptance of the legitimacy of the trade-offs involved.

Legal consultation

5.1.8 A principal feature of the "compliance" approach to consultation is that it need not commence until the party doing the consultation has developed a proposal. The process of developing the proposal itself can take place entirely in-house without imperilling compliance. As discussed below, this can readily lead to a public perception that consultation, notwithstanding the best intentions of the party consulting, is effectively consultation on a fait accompli.

Information gathering

5.1.9 RHAs (or for that matter other bodies required to consult) do not have a monopoly of information within their area of responsibility. Within any RHA, there is a wide diversity of communities in geographic, socio-economic and demographic terms. Accordingly, consultation can play a significant role in providing for the RHA information on community needs, preferences and possibilities which will not otherwise be available. This requires the use of processes/mechanisms which can better inform not simply the RHA's final decision making, but the initial judgements which its staff make on issues such as health needs and appropriate responses.

5.1.10 This approach to consultation also provides a means for informing communities on the constraints faced by the RHA itself. One of the key findings in the "Review of Community Consultation" cited above is that 'health reforms' are still poorly understood by a large section of the 'community'. Many people are confused about the purpose and objectives of the reforms, the structure of the health system and distinctions between the functions of government, the Ministry of Health, Regional Health Authorities and providers, particularly Crown Health Enterprises."

Managing public pressure

5.1.11 This matter is discussed in more detail in Section 6.4 below. The essential point is that community involvement may well be a pre-requisite to mitigating public pressure for increased expenditure within the health system.

Divided responsibility

5.1.12 At least within the hospital (CHE) sector, the issue of consultation/community input has been further complicated by uncertainty as to who is obliged to do what. Crown Health Enterprises have no obligation under the Health and Disability Services Act 1993 to consult. Instead, whether and when they consult is governed by:

- Conditions in their contract with the RHA. A typical provision, from a CRHA contract, is:

  > If you intend to change the way that you provide services, you will develop a consultation plan and implement it with all communities including Iwi/Maori that may be affected. In large organisations, service participation must be part of both the planning and consultation processes.

  We understand that the CRHA largely leaves to the judgement of individual CHEs when and how they act in response to this requirement.

- Management decisions on the measures which they should take as part of managing their business to ensure that they have an adequate understanding of user requirements and the pressures which might come to bear on their business.

5.1.13 Amongst the difficulties which have arisen, as regards CHE consultation, we note the following:

- A reluctance of CHEs to release information which may be seen, from a community perspective, as essential for meaningful dialogue, because of the constraints of “commercial confidentiality”;
- Uncertainty as to the boundary between RHA responsibility and CHE responsibility. RHAs are responsible for purchasing services on behalf of the community but take the view that they are constrained, amongst other things by Commerce Act considerations, from specifying where, or even how, those services should be provided.

5.1.14 The Hawkes Bay Regional Hospital situation provides an example. The CRHA's 1996 document "Healthcare in Napier" includes the following:

> *"Central RHA has decided not to specify where services should be delivered from in Napier. We are aware of the strength of public commitment to the Napier Hospital site, and appreciate that leaving the location of services undetermined is a significant change from what was in the 1994 document.*
>
> *"It is not Central RHA's role to specify the site from which providers will operate. Central RHA is responsible for a range of functions, including monitoring health, assessing the need for health services, and purchasing those services. As such, we can only specify the levels of services that will be purchased, quality standards that providers must meet, and criteria that determine who needs to have easy access.*
>
> *"Central RHA cannot specify the site services should be provided from, as this would mean limiting who could provide the service. Specifying the site would also significantly limit a provider's ability to be innovative and improve services. It could also be seen as anti-competitive and in breach of the Commerce Act."*

5.1.15 Although these comments are technically correct, they do not address what is typically a major public concern, namely, where will services be delivered from. As the Napier example makes clear, public understanding of what constitutes reasonable access to services is very different from the quite generalised requirements of the ministerial guidelines.

5.1.16 At the very least, this highlights the importance of co-ordination between the CRHA and key providers in dealing with community concerns and in achieving a clear and common understanding between the CRHA and those providers as to who has what responsibility in terms of the planning of health services and ensuring that there is adequate community input/consultation.

5.2 CURRENT DEVELOPMENTS AND RESPONSE TO EXPERIENCE THE PRACTICE OF COMMUNITY INPUT IN HEALTH PURCHASE: THE EXPERIENCE OF CRHA

Overview

5.2.1 Over the period since they were established, the four RHAs have put considerable effort into addressing and developing the role of consultation in health purchasing at the user, and also wider community, level. Consultation committees and groups have evolved. The RHAs each have consultation and communication policies in place, with manuals setting out principles and guidelines. Each has undertaken a substantial number of formal consultations, and has accumulated a body of

experience in consultation approaches, processes and methods. Various documents put out by the RHAs, and discussion within (and more recently between) the RHAs regularly emphasise the theme of working with communities.

In a review of literature on community consultation processes undertaken for the Southern Regional Health Authority, the purpose of RHA consultation is described as "to find out what people in the region need in the way of health services, how well those are covered by present arrangements, that quality measures are in place, and what effect new policies might have on people's health and on their access to services".[3]

5.2.2 This section highlights CRHA's experiences in consultation, and the direction of current developments and current thinking.

It needs to be noted that in common with the other RHAs, community involvement has in effect been largely equated with consultation. Most of what follows in Section 5.2 therefore relates to consultation rather than anything wider. As will be explored in Section 7.1 below, consultation is but one element in a continuum of involvement that encompasses processes and activities ranging from marketing, to partnerships, to delegated control[4].

Another feature of consultation as it has occurred over the past four years, common to the RHAs, is that it has been more issue-driven than relationship-driven. This may be regarded as a reflection of the relative newness of the RHAs and the time it takes to build up the relationships and networks that allow consultation to be grounded in knowledge of communities and the different perspectives to be found within communities. Such knowledge then becomes the setting in which consultation on particular issues occurs.

5.2.3 These limitations may be seen as characterising a stage in the evolution towards effective community involvement. They should also be put in the context of the role other health sector bodies play in seeking community involvement:

- The Public Health Group within the Ministry of Health has a statutory requirement to consult. Its predecessor, the Public Health Commission, was one of the earlier publishers of health consultation guidelines, covering all stages from basic ground rules, selection of people to consult, methods to use and evaluation;

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[3] "A Review of Literature on Community Consultation Processes", Jill Nuthall, February 1966 (revised version) p.5.

[4] "Participation" is another term that is sometimes used synonymously with "consultation". The term "participation" may be used in two different ways: as a generic way of referring to any form of community and consumer engagement; or to mean involvement that accords to community and consumer interests a role close to or part of actual decision-making. Both usages are valid. We adopted the latter more precise usage, for the purposes of this report. See the table in Paragraph 7.1.7 for participation as one form of community involvement. We note that the Steering Group to Oversee Health & Disability Changes adopts the broader meaning.

- The National Health Committee, which provides independent advice on health priorities, what kinds of services, and circumstances in which services, should be publicly funded, is required by statute to consult before putting advice to the Minister of Health. Fundamental to its role is the identification of community values and preferences and integrating these into frameworks for setting health priorities. The NHC incorporates consultation with the public, health service consumers and health providers and professionals into all its projects, underlined by its belief in the importance of public debate and public scrutiny of the basis on which health funding decisions are made. It utilises a range of consultation methods according to the nature of the issues and the purpose to be served. The NHC sees consultation as a means for supporting and legitimising its work and increasing the chance of uptake of its policy advice. Consultation undertaken by the NHC also feeds into the RHAs through the NHC's role in developing principles for purchase (which are translated into the policy guidelines and funding agreements for the RHAs), and in developing approaches to defining access criteria[5];
- The CHEs do not have statutory obligations to consult. Instead, consultation is dealt with as contractual obligations. We understand that these are currently being re-specified and made more explicit. CHEs will be required to consult whenever a significant change in services is planned.

The CRHA's past experience

5.2.4 As noted in paragraph 5.1.5, formal consultation has been the primary means by which the CRHA has sought community input to policy and service proposals. This is in part a consequence of the legal obligations to consult, discussed in Section 5.1.

5.2.5 The CRHA recognises that formal consultation has had its shortcomings, both in terms of the sufficiency of compliance-oriented formal consultation, and in terms of how well consultation initiatives have been, or can be, managed.

5.2.6 Among the steps the CRHA has already taken to improve its consultation procedures is the development of a "Consultation Protocol and Guidelines" document which details minimum requirements for when and how to consult. Like other public bodies which have adopted such policies, the Protocol incorporates the principles set out in the Court of Appeal judgement on the *Wellington International Airport* case.

5.2.7 Also in line with other public bodies, the CRHA has employed a range of methods for formal consultation (some of which it acknowledges are not so much consultation as processes for the good management of the business). Those used by the CRHA include:

- Publications;

[5] For a further discussion of the NHC's work in relation to consultation, see "Specifying Health Services", a discussion document compiled for Central RHA by Carol Clayton and Liz Wall, March 1997.

- Freephone;
- Research - sub regional needs assessment projects;
- Discussion papers;
- Public meetings;
- Hui;
- Focus groups;
- Advisory groups;
- Proposed strategies seeking submissions;
- Seeking expert opinion.

It may also be noted that the CRHA does not see itself as being always necessarily in the "driving seat" of a consultation process. Consultation on service provision consequent upon the closure of Dannevirke Hospital was, for example, run by a mayoral task force which brought the different parties (the CHEs, providers, professionals and community) together under the leadership of the Mayor, facilitated by the CRHA.

5.2.8 These methods have been variously used in the consultation programmes the CRHA has adopted for planning and decision making. Consultation occurs at three broad levels:

Purchase planning - consultation on draft purchase intentions for the forthcoming year. At the "macro" level (purchase strategies for the region as a whole), examples are the 1993 and 1994/5 Purchasing Directions documents and the 1993/94 Annual Report, all of which included questionnaires seeking comments, and a submissions process. At the service-specific level for the region examples are the service strategies/draft strategic plans for primary care, Maori health, intellectual disability, physical, neurological and sensory disability, maternity, child health and alcohol, drug and tobacco services. The consultation process in the past has tended to focus on submissions and public meetings as the means for the community to have its say, and to entail three formal steps: the release of a draft discussion/strategy paper containing preliminary issues and options; a period for formal comment; analysis and final document.

Service planning - consultation on assessing the health service needs of particular communities. Examples are the needs assessment consultations in Porirua ("Strong Links: Building Better Services to Meet the Health and Disability Support Service Needs of People in Porirua", 1994); Wanganui ("Poutama Whirinaki: Interwoven Paths", 1996); and Napier/Hastings ("Nga Ara Poutama: Pathways", 1996). These and other similar projects have involved extensive community input in several stages, from initial information gathering and identification of issues to final proposals, with community feedback as part of the process. They have taken in community groups, Maori and health providers.

Service development/provision - consultation on particular service proposals and service changes, such as the need for the RHA to plan for the alternative provision of services to meet the needs and preferences of local communities, when a CHE proposes to exit from a service. Past examples are consultation over the decision by Health Care Hawkes Bay to amalgamate the hospitals in Napier and Hastings into a regional hospital in Hastings, and Mid Central Health's decision to close Dannevirke Hospital. The Hawkes Bay case was marked by considerable confusion over the roles of the CRHA and the CHE, which flowed into public confusion over the whole consultation process. Subsequently the CRHA embarked on a fresh consultation process on the purchase of health care in Napier, which clarifies its role as specifying levels of service to be purchased, quality standards and access criteria, not involvement in where services should be delivered. A key feature of consultation in the Dannevirke case was the role the CRHA team adopted of "leading by facilitating" (the formal avenue for consultation being the mayoral taskforce).

The CRHA also consults on specific service design and delivery, for the purpose of fulfilling its purchase responsibilities. Matters on which it may consult include draft service descriptions, the identification of outcomes for a particular service, quality measures and best practice. This gets the RHA into a degree of detail where a very clear line on its purchase role is necessary, to distinguish between consultation which informs and improves purchase specifications, and consultation that runs over into provider responsibilities.

5.2.9 Community Health Groups and Health Councils

Within the CRHA region there are 41 CHGs, all but three (those established as women's health groups) having a mandate to deal with all health issues. There are also two health councils which cover the geographic area of their CHE.

The CHGs are extremely diverse, substantially voluntary bodies whose commitment is recognised by the CRHA through a contribution to operating costs and through support from the network of community co-ordinators (now the Community Liaison Managers), who are the main communication channel between CHGs and CRHA.

While the effectiveness of CHGs and the quality of the relationship between them and the CRHA have been problematic, the CRHA has been impressed by the significant commitment of the CHGs to community consultation, and the expertise of individual CHG members. It has recognised that a number of issues need to be addressed if CHGs are to play a full role on behalf of their local communities in consultation.

In paragraph 7.2.5 below, the part played by the Statement of Intent in recognising the role of CHGs is considered.

5.2.10 Consultation with Maori

The CRHA's Maori Health Development Group is responsible for direct consultation with Maori. Its approach has consistently been to start with Maori, asking Maori about their health needs and documenting and reporting those upwards, in reverse of the conventional model of consultation down. The Group has brought to its consultation processes the particular questions and methods relevant to Maori. The emphasis on oral and face-to-face consultation has been an important counter to the usual reliance on written processes.

An assessment of CRHA's past experience

5.2.11 Because consultation by the CRHA has tended to occur service-by-service, and variations have occurred year-by-year as different approaches to consultation are tried, no clear pattern is evident from a review of experience to date. Variations have occurred in such respects as choice of consultation method and weighting of provider focus relative to consumer/community focus. The use of different consultation methods and practices is not in itself a problem. Indeed, it is important to match approach to the purpose of the consultation process. Variations in the quality of consultation can however reasonably be considered to have a negative influence on community and consumer perceptions of the CRHA and the purchase process generally. In common with consultation by other public agencies, the CRHA's processes have in some respects left people as spectators in planning and decision making, and with a sense of relative lack of participation despite the amount of consultation activity. An example is when the CRHA appears not to have acted on community input, and no reasons are given.

It is fair to say, too, that rising expectations mean that even good consultation processes may not leave all parties happy. This is especially true in relation to expectations that views expressed during consultation will always be reflected in final decisions.

There have also been some very positive experiences, as in the Dannevirke Hospital case. There, positive feedback from the local community on the part played by the CRHA's team, and particularly acknowledgement of the commitment to genuine consultation in the face of an initially inauspicious environment for consultation, can be taken as a measure of the CRHA's effective management of a difficult consultation.

5.2.12 Factors in the internal environment for, and management of, consultation appear to have been another contributor to variations in the style and quality of the CRHA's consultation experience, with consequences for community perceptions. One example is when internal decisions are delayed, causing the CRHA to fail to meet its part of the consultation timetable it has imposed, attracting criticism and loss of credibility. This is a matter of organisational commitment. Another example is when the outcomes of research-based consultation (as in needs assessments) are not reflected in what actually happens in contracts and service delivery. The former has not always flowed through into policy and contracts (which is where on-the-ground

decisions are made on where the money gets spent, based on the close contract relationship with providers and the service knowledge of the CRHA managers).

5.2.13 An overall assessment of the CRHA's past experience in community consultation would suggest that consultation at the "micro" level has been more focused, and has developed further in terms of community and consumer relationships, than consultation at the "macro" level. This is understandable, given the relative ease with which interested communities can be identified at the "micro" level and the ability on both sides to be well informed. A more considered assessment of "macro" level consultation can perhaps be made some time after the new purchasing structure has been in place, when the relationship between national and regional purchasing responsibilities has bedded down.

5.2.14 The CRHA has profited from its experience with consultation. Managers have seen it as a source of learning and insight, offering benchmarks against which to make further advances in consultation, and recognition that in a number of instances, if doing things again, they would do them differently. These insights are reflected in changes already made, or being planned or thought about.

Current and future developments

5.2.15 Recent internal restructuring and the creation of a management structure for consultation is beginning to highlight the scope for more internal co-ordination, which should in turn enhance external credibility. Along with this change is going better internal planning which is, among other things, benefiting the role of the former community co-ordinators who, as Community Liaison Managers (CLMs), can contribute more strategically to consultation. The community co-ordinators have, in the past, been one of the diverse ways in which the CRHA has engaged with its local communities, particularly in servicing and facilitating the Community Health Groups and other groups. The seven CLMs still have varied roles, but are more able to play an extended involvement in consultation through taking on the tasks of meeting facilitation, data recording and analysis, planning of processes and use of focus groups. With the development of the deeper skills required for these roles, the CLMs can become key players in the building of community and consumer relationships and of informal networks, including getting to the harder-to-reach consumer groups. These informal networks are an aspect of the all-important, on-going informal relationships which can be forged as part and parcel of the management task at all levels within an RHA - the places where public perceptions are often formed, and where community input can work well.

5.2.16 An even more recent development has been the bringing together of the consultation and communication managers of the four RHAs, and officials from other health agencies, to share experience and ideas about community and consumer involvement. The managers' meeting held in March of this year generated a raft of action points, practical agendas and best practices, including practices for Maori and Pacific Island consultations. Among the issues worked on at the meeting were:

- Consultation as part of a change process and having a community development orientation;
- Co-ordination among health agencies;
- Internal credibility and integration of consultation into service units.

Another meeting is planned for October 1997, to focus particularly on concepts of best practice which the Chief Executives of the four RHAs have agreed should go forward into the new health funding arrangements to be implemented in 1998.

5.2.17 The CRHA has a number of plans for improving consultation in ways that will contribute to enhanced credibility. These include:

- the preparation of an organisational plan for consultation, which is underway;
- more emphasis on making connections among the different health service areas so that consultation can be more consistent between them, and thought about at a higher co-ordinated level where key issues in one area can be related to the issues in another;
- better evaluation of consultation, and refinements to methodology (more selective use of public meetings, more use of focus groups and expert input, not relying solely on one method);
- clearer definition of when the CRHA is consulting and when it is doing other things, so as to avoid creating expectations that cannot be met;
- further development of the CRHA's skill base in consultation;
- a review of the structure of Community Health Groups, and discussions with local government on how to develop health groups with a mandate to represent local health and disability issues.

5.2.18 From our interviews with the CRHA managers, key issues from past experience were:

- The need to distinguish between **consultation** and **communication**. While the two had some basic similarities, the tools were very different, as was the fundamental approach. One way to make the distinction is to see communication as being about 'sharing', and consultation as about 'seeking'.
- Recognition of changing public attitudes and understandings about consultation. The public, and some particular communities, had gone through an extensive 'educative' process over the past several years, acquiring greater skills and sophistication in consultation. The CRHA has seen a progression occurring along a learning curve, from acceptance of simply 'being consulted', to an expectation that people will be informed of the decisions taken, and to the further expectation that consultation means being heard and seen in the eventual outcome.
- Realistic timeframes were an essential element in successful consultation. Some processes (the Porirua Needs Assessment process is an example) take many months to go through all stages. Few people understood the amount of work that went into a completed consultation process, and this needed to be clarified and people given clear indications of the likely timeframe in advance

A common theme in any discussion about consultation is 'consultation fatigue' or 'over-load'. To the extent that it occurs, it is frequently attributed to public experience of consultation as a one way process. It would seem to be less of a problem when consultation is with the consumers of a particular service - often the case with much of the CRHA's service planning and development consultation - because consumers have a more immediate sense that something can change, and therefore a continuing motivation to participate in consultation.

5.2.19 Trade-offs in the consultation process

Another result of the CRHA's accumulating experience with consultation is an increasing understanding of the trade-offs inherent in the consultation process. Some of those identified in our interviews were:

- The trade-off between the objective of letting people 'have a say', and the objective of obtaining the best possible information from community sources. Public forums often combine both objectives, possible achieving only one or the other, or neither well.
- The trade-off between 'capture' and 'participation'. Should any particular group of interests be excluded because of the risk of dominance? This question often arises in relation to provider and professional interests.
- The trade-off between competence and representativeness. People chosen as representatives on community organisations could be assumed to be in touch with their community constituency, but did not necessarily have the competence to make judgements on complex and technical matters. This trade-off could be

resolved by balancing both skills within the consultative group, or by having processes that separately obtained, and then weighed up, the different perspectives.

- The trade-off between effective consultation and the volume of consultation activity. Effective consultation is a matter of good management which, it was suggested to us, is becoming more demanding - and needs to be seen as requiring the same attention as the management of any other part of the organisation's business. Some of the consultation tasks now on managers' desks include the preparation and dissemination of information to inform the consultation process, recording and disseminating the consultation, feedback to the community on the outcomes of consultation and steps to make it easier for people to take part. At the same time, the volume of consultation activity is rising, driven partly by the organisation itself (to comply with legislative requirements, and for business purposes) and partly by consultation demanded by or initiated from the community. These potentially competing trends require the careful assessment of the scale and scope of expectations on managers, and of the work put on the community.

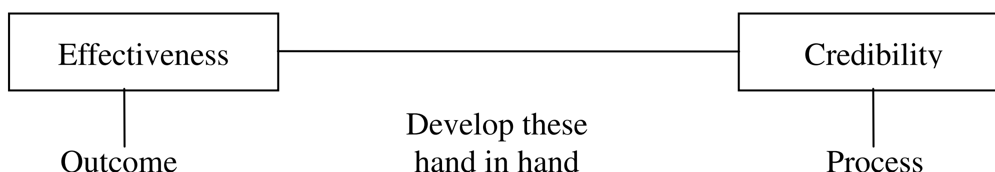
5.2.20 A very important distinction can be made between two drivers of consultation:

- consultation driven by the RHA itself, oriented towards achieving RHA objectives;

- consultation initiated by the communities, driven by a need felt in the community.

The latter can be as important and useful as consultation initiated by the RHA itself.

5.2.21 A further consideration is the weight that is placed on community input in final policy decisions. What may be more important to the community interest is the effectiveness of outcomes on the one hand, and the credibility of the process on the other:



The effectiveness of consultation does not require that people get what they want. People may be more likely to be satisfied with a decision that does not fully reflect what they want, if the consultation process has high credibility and health service outcomes are demonstrably improved.

5.2.22 Finally, what can be drawn from the CRHA, and no doubt other RHA, experience is that the establishment of prescriptions for consultation need to be treated with caution. It is in effect impossible to draw a perfect formula from past experience, because of the range and number of factors that go into each melting pot. In any given case, when all of the factors in the community and all of the interests of the different players are added in, there should be a combination that works. This requires that within planned processes, there needs to be latitude to simply respond to circumstance and to the mood and feelings of people, and at each point in the process, to work out what should happen next. That said, a management framework is still necessary, to ensure a clear path ahead and to articulate shared expectations.

6.0 WHY PUBLIC INVOLVEMENT?

6.1 INTRODUCTION

6.1.1 In this section we look at the case for public involvement at two separate levels. The first we term the **operational** level, which we discuss in Section 6.2. This concerns the case for putting in place/enhancing means for public involvement in the New Zealand health system which has. The focus of our attention is on New Zealand's health system and the needs facing its managers. In considering the case for public involvement, we have had the opportunity of reading chapter three of "Participating in Health," the Report of the Steering Group to Oversee Health and Disability Changes. Substantially, we agree with the argument advanced in that chapter (Our principal reservation is with the steering group judgement not to be prescriptive in the form or method of participation. We believe, and develop this theme in section 7.2 below, that there is a need to be prescriptive as to the creation of an appropriate structure and framework to enable community participation). We then, in the final part of this section, consider the argument that public involvement can contribute to the management of fiscal risk.

6.1.2 We specifically endorse the steering group judgement, in respect of participation, that:

> *Participation provides an opportunity for the community to express a synthesis of their individual values and preferences to the provider of the goods and/or service. We consider this aspect of community participation is critical to the public health and disability sector for three important reasons:*
>
> - *in the absence of choice, participation provides a means for the sector to be responsive to the community it serves.*
> - *participation reinforces the fact that the sector is ultimately accountable to the community it serves;*
> - *participation engenders community confidence in the sector through the empowering forces of ownership and making a difference."*

6.1.3 In section 6.2 which follows, we make further comment on some of the more practical issues, including limitations on various survey and research techniques. We reserve until section 7.1 substantive discussions of a range of possible means of consultation/participation.

6.1.4 The second element of the case for public involvement we have termed **strategic.** In Section 6.3, we look at the emerging debate on the relationship between social capital, civil society and good government. This discussion is not specific to the health sector and nor are there yet in the debate firm and unequivocal conclusions which can be drawn from it. Nonetheless, we regard it as an important component

of this project as work which is exploring the context in which governments seek to function and deliver on important social objectives.

6.1.5 Finally, in section 6.4, we review the potential for public involvement to contribute to the management of fiscal risk.

6.2 THE OPERATIONAL ARGUMENT

6.2.1 The shift from the former Hospital Board/Area Health Board system to the present system based on a separation of purchaser and provider was a response to a number of perceived failings in the former system. Not all of these were concerned with matters such as inappropriate incentives, role conflict, and lack of accountability. Government was also concerned that the former systems lacked the means needed to understand and respond to community preferences.

6.2.2 The Department of Health's October 1990 post election briefing paper recognised this with its statement of a proposed principle of efficiency as :

> *Decisions about what level and pattern of health services are provided should be made on the basis of a full examination of competing claims for the community's resources. Competing claims should be assessed in terms of the community's preferences for health and other services, and the costs of providing these.*

6.2.3 It drew the policy implication, from this principle, that:

> *Consumers of health services should participate in the provision of health services, and be involved in decisions about what health services are provided and how they are provided.*

Note, however, the judgement in paragraph 4.17 above that there may have been different expectations within the community on the one hand and on the part of ministers and officials on the other of what community input might mean.

6.2.4 Although that briefing paper, and departmental management of the time, did not play a central role in the subsequent reforms, this particular theme was picked up, for example, in the Green and White Paper's emphasis on lack of community control. This was reflected in the paper's statement, already quoted, that "there must be a clear distinction between those moral issues into which the community must have an input, for instance defining "core" services, and those management issues which are less amenable to public consultation, and are best left to those who are expert in the area."

6.2.5 It is our judgement that a shift to a purchase model, with the major institutional and operational changes this necessitates, has placed substantial strain on the health system in a process of change which is still far from complete. The priority for RHAs has been developing and putting in place provider contracts and monitoring

systems covering a very large number of providers and services. In our view, such a situation inevitably gives priority to dealing with those matters which are an absolute requirement in preference to those which are seen as highly desirable. It also emphasises a compliance approach over and above a consultative one (in the popular as opposed to technical meaning of the word). To the extent that this has seen an emphasis on provider contracting/consultation rather than on involvement of the community, we would see this as a quite understandable by-product of the nature and extent of the reforms.

6.2.6 As has been acknowledged by the CRHA (see paragraph 5.1.4 above) there has been less emphasis on consultation with the community. In this section we wish to make the point that consultation with the community is not simply a matter of allowing people to feel that their views have been recognised and that the health system is attempting to be responsive to their concerns. It should also, and importantly, be an integral part of services planning. Communities can be invaluable sources of information on needs, opportunities and alternatives for delivery of health services. In a parallel project being undertaken for the CRHA on the future of community health groups, we have been cited examples of service delivery initiatives, undertaken by the CRHA, which were planned without the benefit of knowledge available within the local community which, had it been available to the CRHA at the beginning of its planning process, could well have resulted in a different, more efficient and less costly means of meeting the need concerned.

6.2.7 Conventional market research techniques, increasingly favoured as a means of testing public opinion, do face limitations and cannot be relied on as the sole or even principal means for community involvement. For example:

- Telephone based survey techniques, by definition, only reach people with telephones.
- Mail surveys, unless they achieve very high response rates, may well have an inherent bias arising from the different characteristics of those who respond and those who do not.
- Face to face techniques, such as focus groups, can be a useful means of sampling opinion on an ongoing basis but:
  - ⇒ The very fact of involvement in a focus group, and the knowledge skill which members acquire by reason of that involvement, can make them and their responses atypical of the communities from which they are drawn.
  - ⇒ Focus groups may be a useful tool to sample opinion but less effective in drawing out knowledge about actual circumstances or opportunities within the community unless quite significant numbers are involved.

6.2.8 These difficulties have been recognised elsewhere. The Lambeth Southwark and Lewisham Health Commission, in a publication "Developing Health Locality Purchasing Intentions 1995-96" had this to say:

"We are much less skilled at estimating the balance of local opinion than at counting how many people die from a particular cause. This means that the criteria about which we are usually less certain is what local people really want. Surveys and consultations help, generally these contact only a small proportion of people who may not represent accurately the view of the majority."

6.2.9 These limitations on market research techniques make the case for developing a means for dialogue between health and disability services purchasers and the communities they serve which has the potential to be ongoing, and to tap into knowledge about local preferences, needs, opportunities and alternatives in a representative way. As an approach, this clearly requires ongoing commitment, appropriate resourcing, and a level of trust and acceptance within the local community that it will be effective. This issue is discussed further in Section 7.2 below, "Options for Use in New Zealand's Health Sector".

6.3 THE STRATEGIC ARGUMENT

6.3.1 In this section we look at the debate, internationally, on the relationship between social capital/civil society and the capacity for effective government. In association with this, we consider recent work on the concept of "trust" and its role in reducing transaction costs and building confidence in the legitimacy of institutional performance.

Social Capital

6.3.2 In a much cited article in the January 1995 issue of the *"Journal of Democracy"* Professor Robert Putnam describes the concept of social capital as:

"by analogy with notions of physical capital and human capital - tools and training that enhance individual productivity - 'social capital' refers to features of social organisation such as networks, norms, and social trust that facilitate co-ordination and co-operation for mutual benefit."

6.3.3 He goes on to comment that

"for a variety of reasons, life is easier in a community blessed with a substantial stock of social capital. In the first place networks of civic engagement foster sturdy norms of generalised reciprocity and encourage the emergence of social trust. Such networks facilitate co-ordination and communication, amplify reputations, and thus allow dilemmas of collective action to be resolved. When economic and political negotiation is embedded in dense networks of social interaction, incentives for opportunism are reduced. At the same time, networks of civic engagement embody past success at

collaboration, which can serve as a cultural template for future collaboration. Finally, dense networks of interaction probably broaden the participants' sense of self, developing the "I" into the "we" or (in the language of rational-choice theorists) enhancing the participants' "taste" for collective benefits."

6.3.4 In perhaps his best known work, "Making Democracy Work: Civic Traditions in Modern Italy"[6] Putnam drew out the relationship between social capital, civic society and effective government. The work was a longitudinal study of the effectiveness of regional governments in Italy. Regional government was created, in 1970, as part of a major restructuring of local government. The simultaneous creation of a number of political institutions, with similar formal powers and resources, but operating in different communities, provided a unique opportunity for a comparative study to test factors influencing institutional effectiveness and public acceptance of their legitimacy.

6.3.5 Broadly, the contrast was between regional government in the north of Italy and regional government in the south. In the north, regional governments were seen as strong, well managed, effective and enjoying the confidence of their communities. Performance across a range of variables, such as processing enquiries, applications, consents, etc., was good. In contrast, regional government throughout much of southern Italy was far more arbitrary, inefficient, and lacking in public confidence. There was a strong implication that, in the north, outcomes were rights based, whereas in the south they were influence/connections based.

6.3.6 Underlying this was a centuries old difference in the patterns of civil engagement between the north and the south. Historically, northern Italy had been made up of a series of largely self-governing city states with a strong emphasis on the role of the citizen. Levels of civil engagement were high, with people commonly involved in a number of different voluntary associations. The one which most appealed to Putnam, and which seems to have a high correlation with other measures of social capital, was involvement in local choirs. (See footnote 7 below for his observation on the correlation between choral societies and the time it takes to get health bills reimbursed).

6.3.7 The south, in contrast, had been governed by a strong centralised monarchy, with an arbitrary approach to rights, encouraging an environment of patronage rather than civil engagement and promoting a high level of distrust which Putnam found was still pervasive.

6.3.8 The principal inference drawn from his Italian work was that the success or failure of the regional governments which he studied was very much a function of the pre-existing level of social capital and the extent of civic engagement in the regions for which they were responsible, something which he clearly believes can only be built up over a long period of time. In his work, the relationship is uni-directional.

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[6] (1993) Princeton University Press, Princeton N.J.

Strong civil society resulted in strong regional government (remembering that Putnam's study, although it covered 20 years, commenced with the establishment of regional government in 1970)[7]. In related work, looking at civil society within America, Putnam has documented what he sees as a decline in civic engagement which parallels a decline in civil society and in America's political institutions. This work is on-going and issues of causality are still very much a matter for debate. What is consistent, in both Putnam's Italian study and in the work which he and others have been undertaking in a US context, is the view that there is an important bi-causal relationship between the strength of civil society and good government.[8]

Civil Society

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[7] An interview between Putnam and the president of the American Association for Higher Education in the lead up to the Association's 1995 National Conference on Higher Education provides a good insight into Putnam's thinking on this issue: *Q*. You found, to over-simply horribly, that different regions of Italy varied enormously in things like rates of membership in sports clubs, and that associational ties like sports club membership turned out to be critical predictors of the quality and success of the regional governments you were tracking. *A*. Yup. You tell me how many choral societies there are in an Italian region, and I will tell you plus or minus 3 days how long it will take you to get your health bills reimbursed by its regional government.

Then turning to the American situation: *Q*. Say a bit more about how our associational life is tied up with how well our democracy works. *A*. Well, lets take the toughest case, which is my claim, partly but not entirely tongue-in-cheek, that the fate of the republic hangs on the fact that Americans are no longer engaging in league bowling.

First, when you participate in a bowling league, interacting regularly with the same people week after week, you learn in practice what de Tocqueville called "habits of the heart". You learn the personal virtues and skills that are the pre-requisites for a democracy. Listening, for example. Taking notes. Keeping minutes. Taking responsibility for your views. That's what is different about league bowling versus bowling alone.

[8] In the same interview, Putnam acknowledged that there is less agreement on what gives rise to strong civil society than there is on the relationship between the strength of democracy and a strong civil society. The following exchange sets this out: *Putnam*. Well, as you know, nothing is settled in academic life. But let me distinguish two propositions that I laid out in the book, one of which is pretty widely shared, the other of which is still debated.

The first proposition is that if you want to know why democracy works in some places and not others, de Tocqueville was right … it's the strength of civil society.

But the second is that if we ask why some places have a stronger civil society than others … why there are more football clubs than choral societies in one region than another. …the answer gets more complicated. As you know, in my book I went back a thousand years and traced some deep historical roots. But there is professional debate about this historical argument. *Interviewer*. You also found in your work in Italy that the various forms of civic engagement are inter-related. Participation in civic associations, newspaper readership, voter turnout, … they all go together. *Putnam*. That's right. If a region is high on one, it's high on the others.

That's true, by the way, in the United States, too. Just yesterday, I was looking at how voter turnout, membership in groups and indicators of social trust are all correlated in different states. People in Minnesota, for example, are the most trusting people in the United States. They are also among the most intense joiners. And they are the most likely to turn out to vote.

6.3.9 The term "civil society" is not a reference to governing structures as such, nor is it simply social capital by a different term. Rather, it is a term descriptive of a broad set of social interactions between individuals and groups, some formal, some informal, which take place in a domain which is neither purely individual, nor commercial nor governmental. The American political scientist Benjamin R Barber has described civil society in these terms:

> *"Civil society is a societal dwelling place that is neither a capitol building nor a shopping mall. It shares with the private sector the gift of liberty; it is voluntary and is constituted by freely associated individuals and groups. But unlike the private sector, it aims at common ground and consensual, integrative, and collaborative action. Civil society is thus public without being coercive, voluntary without being private.*
>
> *The best way to think about civil society is to envision the domains Americans occupy daily when they are engaged neither in government (voting, serving on juries, paying taxes) nor in commerce (working, producing, shopping, consuming). Such daily business includes attending church or synagogue, doing community service, participating in a voluntary or civic association, joining a fraternal organisation, contributing to a charity, assuming responsibility in a PTA or a neighbourhood watch or a hospital fundraising society. It is in this civil domain such traditional institutions as foundations, schools, churches, public interest groups, voluntary associations, civic groups and social movements belong. The media too, when they place their public responsibilities ahead of their commercial ambitions, are better understood as part of civil society and not the private sector"*

6.3.10 The growing interest in issues of social capital and civil society arises from two related concerns:

- A substantial endowment of social capital and, flowing from that, a healthy civil society, are pre-requisites to effective government and, in particular, the willingness of individuals or groups to accept government actions as legitimate even when individual actions (such as rationing particular social services) may run counter to their own individual interests.
- The way in which governments, and the public institutions dependent on them, conduct their affairs and make their decisions have the potential to undermine social capital and civil society and hence the effectiveness and legitimacy of government itself.

6.3.11 The most articulate discussant of this issue, at least as it has developed in the US, is Michael Sandel, Professor of Government at Harvard University, in “Democracy’s Discontent: America in Search of a Public Philosophy”.[9]

6.3.12 He draws a sharp contrast between the public philosophy which had informed American political debate in the almost two centuries between the declaration of independence and the end of the second world war, and the public philosophy of the second half of the twenth century.

6.3.13 The former he categorised as republican political theory and the latter as liberal political theory. Of these he had this to say:

> ***Republican*** *Political Theory*
>
> *“Central to republican theory is the idea that liberty depends on sharing in self government. This idea is not by itself inconsistent with liberal freedom. Participating in politics can be one among the ways in which people choose to pursue their ends. According to republican political theory, however, sharing in self-rule involves something more. It means deliberating with fellow citizens about the common good and helping to shape the destiny of the political community. But to deliberate well about the common good requires more than the capacity to choose one’s ends and to respect others’ rights to do the same. It requires a knowledge of public affairs and also a sense of belonging, a concern for the whole, a moral bond with the community whose fate is at stake. To share in self-rule therefore requires that citizens possess, or come to acquire, certain qualities of character, or civic virtues. But this means that republican politics cannot be neutral toward the values and ends its citizens espouse. The republican conception of freedom, unlike the liberal conception, requires a formative politics, a politics that cultivates in citizens the qualities of character self-government requires”.*
>
> ***Liberal*** *Political Theory*
>
> *“Its central idea is that government should be neutral toward the moral and religious views its citizens espouse. Since people disagree about the best way to live, government should not affirm in law any particular vision of the good life. Instead, it should provide a framework of rights that respects persons as free and independent selves, capable of choosing their own values and ends. Since this liberalism asserts the priority of fair procedures over particular ends, the public life it informs might be called the procedural republic”.*

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[9] (1996) The Belknap Press of Harvard University Press, Cambridge, Massachusetts

6.3.14 Sandel's thesis is that the modern emphasis on individual rights is playing a major role in the breakdown of civil society. His rationale is that the focus on the individual, to the exclusion of the commonweal, strikes at the very heart of the kind of relationships which had underpinned civic responsibility: the willingness to accept, on occasion, that the interests of the collectivity should properly over-ride the interests of the individual.

6.3.15 To express this in another way, Sandel presents an analysis which is extremely sceptical of the view that the public interest is best served by the cumulative impact of the actions of a series of rational self interested individuals pursuing their own best interests as they see them.

6.3.16 Francis Fukuyama, in "Trust: The Social Virtues and the Creation of Prosperity"[10] extends the argument from a somewhat different but complementary perspective. His thesis is that the rational economic model which has come to dominate much of our behaviour is incontestable but that it cannot function without a healthy civil society and all that implies. In the public domain, this includes a trust based approach to the dealings between institutions and the citizens whom they serve.

Trust

6.3.17 The following quotations set out the essence of his argument.

- *"Today, having abandoned the promise of social engineering, virtually all serious observers understand that liberal, political and economic institutions depend on a healthy and dynamic civil society for their vitality. "Civil society" - a complex welter of intermediate institutions, including businesses, voluntary associations, educational institutions, clubs, unions, media, charities, and churches - builds, in turn, on the family, the primary instrument by which people are socialised into their culture and given the skills that allow them to live in broader society and through which the values and knowledge of that society are transmitted across the generations". (Penguin edition P5).*
- *"Over the past generation, economic thought has been dominated by neo-classical or free market economists, associated with names like Milton Friedman, Gary Becker and George Stigler. The rise of the neo-classical perspective constitutes a vast improvement from earlier decades in this century, when Marxists and Keynesians held sway. We can think of neo-classical economics as being, say, eighty percent correct: it has uncovered important truths about the nature of money and markets because its fundamental model of rational, self-interested human behaviour is correct about eighty percent of the time. But there is a missing twenty percent of human behaviour about which neo-classical economics can give only a poor account. As Adam Smith well understood, economic life is deeply embedded in social life, and it cannot be*

[10] (1996) Penguin, London.

understood apart from the customs, morals, and habits of the society in which it occurs. In short, it cannot be divorced from culture". (Op cit P13)

- *"… a society built entirely out of rational individuals who come together on the basis of a social contract for the sake of the satisfaction of their wants cannot form a society that would be viable over any length of time. In a criticism frequently levelled at Hobbes, such a society can provide no motive for any citizen to risk his or her life in defence of the larger community, since the purpose of the community was to preserve the individual's life. More broadly, if individuals formed communities only on the basis of rational long-term self-interest, there would be little in the way of public spiritedness, self sacrifice, pride, charity, or any of the other virtues that make communities liveable. Indeed, one could hardly imagine a meaningful family life if families were essentially contracts between rational, self-interested individuals."*
- *"A parallel argument can be made with respect to economic liberalism. That modern economies arise out of the interactions of rational, utility maximising individuals in markets is incontestable. But rational utility maximisation is not enough to give a full or satisfying account of why successful economies prosper or unsuccessful ones stagnate and decline. The degree to which people value work over leisure, their respect for education, attitudes toward the family, and the degree of trust they show toward their fellows all have a direct impact on economic life and yet cannot be adequately explained in terms of the economists' basic model of man. Just as liberal democracy works best as a political system when its individualism is moderated by public spirit, so too is capitalism facilitated when its individualism is balanced by a readiness to associate." (Op cit P351)*

6.3.18 Fukuyama goes on to make the argument, based on a series of cross country comparisons, that the level of trust within society is a key part of its competitive advantage. He notes:

- *"Wide spread distrust in a society … imposes a kind of tax on all forms of economic activity, a tax that high-trust societies do not have to pay"*
- *"Past a certain point, the proliferation of rules to regulate wider and wider sets of social relationships becomes not the hall mark of rational efficiency but a sign of social dysfunction. There is usually an inverse relationship between rules and trust: the more people depend on rules to regulate their interactions, the less they trust each other and vice versa."*

6.3.19 The application to the role of government seems obvious, especially when faced with inherently subjective and complex decisions such as those which are characteristic of allocation to and within the health sector. Low trust implies not only high transaction costs but also lack of legitimacy and therefore increased pressure both from special interest groups and from society at large, to force change outside the boundaries set by government and the institutions acting under it.

6.3.20 The benefits of a trust-based approach are becoming well recognised in the commercial sector. In "Power of Trust in Manufacturer-Retailer Relationships" in the November-December 1996 issue of the *Harvard Business Review*, Nirmalya Kumar, Professor of Marketing and Retailing at the International Institute for Management Development in Lausanne, Switzerland analyses a number of trust based relationships involving major commercial parties.

A study in New Zealand of corporate social responsibility underlines the same point, highlighting the increasing recognition among companies operating in New Zealand of good community relationships as a strategic asset, particularly to support reputation, and as a key element in the strategic management of longer term profitability[11].

6.3.21 At the level of detail, the article is not directly relevant to the question of public trust and confidence in the health system. However, at the level of principle, it has some very insightful lessons which are clearly relevant to the issue of public confidence in the health system. Amongst the points it makes:

- Most relationships are unbalanced. The key to building a trusting relationship is "to treat the weaker, vulnerable partner fairly. Fairness encompasses two types of justice: *distributive justice,* or the perceived fairness of the outcomes received, and *procedural justice,* or the perceived fairness of the powerful party's process for managing the relationship".
- Trust is rarely all encompassing. You may trust the partner on some issues but not on others.
- Significant change is required to move from a non-trust to a trust relationship. "Many companies that want to move from conventional adversarial relationships to channel partnerships based on trust find that they do not yet possess the capabilities necessary to make the transition. It is not enough for powerful manufacturers or retailers just to start calling their channel counterparts partners. The culture, people, management systems, and attitude that the trust game requires are fundamentally different from those used in the power game. Past practices have to be unlearned before the new approach to managing relationships can be adopted."

6.3.22 The social capital/civil society debate, and the related understanding of the role of trust in the relationships within and between institutions (both public and private) is still unfolding. Nonetheless, it seems clear that some initial conclusions can be relied on at least to the extent of being seen as sensible guidelines for practice in order to minimise risks to public confidence and trust in the legitimacy of institutions and the processes which they follow, especially when the public does not have the choice of exit.

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[11] "Social Responsibility and the Company: A New Perspective on Governance, Strategy and the Community", Adrienne von Tunzelmann with David Cullwick, Institute of Policy Studies, 1996.

6.3.23 First, it seems clear that an approach which is based solely on a rational approach to organisational design and the structuring of incentives is, by itself, insufficient to achieve public acceptance. Second, an overemphasis on a rational/contractual approach can in fact be a means of undermining trust, with a resultant increase in transaction costs and decline in legitimacy. Third, a shift from this type of approach to a trust-based approach requires a substantial cultural shift. In particular, it requires a willingness to accept that the other party has a valid role to play and to create the context in which that role can be played.

6.3.24 As is already being learnt by major commercial firms, the "power play" approach to dealing with ostensibly weaker others is not the best means for achieving optimal outcomes. In a commercial context, it significantly raises transaction costs and blocks off the sharing of knowledge between different parties to their mutual cost. In the health sector, arguably it undermines legitimacy and directs public attention to working through political means in order to counter the perceived failings of the system itself to provide an adequate opportunity for public involvement.

6.4 MANAGING FISCAL RISK

6.4.1 From a fiscal risk perspective, health is probably the most difficult policy area for any government. Public concern at perceived under-performance seems almost always reflected in a demand for more money, regardless of whether or not that is really the issue. The high profile which health normally has electorally can make it hard to hold the line as alternative governments raise their own bids in the political marketplace.

6.4.2 The situation is complicated by the fact that, on any objective measure, demand for health care is rising as the population ages and as new and usually more expensive treatments become available. For an assessment of what this means in a health system with many similarities to our own, see the article in *The Economist* for 3 May 1997 on the National Health Service, "Prognosis: Poor". It notes that the average real annual growth in health spending since 1979 has been 3.1%. Despite this, the "Institute of Fiscal Studies has said bleakly that either significantly more money will have to be found or the NHS's role as a comprehensive provider of free health care will be under threat". The culprit? According to *The Economist*:

- new technological developments in medicine;
- the ageing of the British population;
- rising public expectations.

6.4.3 A further complication is that, even when services are under pressure, there may not be any direct relationship between additional funding and additional delivery. The discussion at page 25 under the heading "Money Not The Answer" in "Providing Better Health Care for New Zealanders," the May 1992 report of the National Interim Provider Board, highlights this with its comment that over the period 1984-85 to 1987-88 a 20% increase in real terms in Vote: Health brought a gain of only

1.8% in public hospital output and its further comment that, in subsequent years, with the government under serious fiscal pressure, holding health budgets constant in nominal terms and thus declining in real terms went along with hospital output increasing significantly in real terms.

6.4.4 Against this background, it is clearly difficult to prove beyond doubt that there is a direct linkage between the level of public confidence in the health system and demand for additional expenditure for its own sake. Nonetheless we argue that any prudent manager would assume that such a linkage does exist. Accordingly it should be seen as only prudent, when considering issues of fiscal risk, to place a high priority on building and maintaining public confidence in the health system and the way in which resources are allocated and priorities set.

6.4.5 The just released Ministry of Health report "Sustainable Funding Package for the Health and Disability Sector" provides an overview of recent New Zealand experience which can be seen as consistent with the view in the preceding paragraphs that fiscal risk is at least partly a function of the level of public confidence. It notes a series of ad hoc funding decisions, commenting "since 1993/94 there have been numerous unplanned additions to Vote: Health. These have been to fund price increases, volume increases (maintain access) and new service initiatives. In addition, rapid population growth in some areas (above that estimated in the official projections) has required revision of the funding adjustment for demographic change." With a sense of irony the report also comments that "increasingly transparent purchase decisions clarify what is not being bought and where access is being reduced. This information provides a focus for public expressions of concern about the inadequacy of health and disability service provision, and tends to create pressure to provide more."

6.4.6 Each of the individual funding decisions it refers to can be seen as an adjustment to meet a specific circumstance arising from unanticipated difficulties or outcomes which varied from forecast. The need to support Crown Health Enterprises running at a deficit is an example. Additional funding for waiting lists could be seen in a similar way: arguably higher than anticipated waiting lists for elective surgery result from higher than anticipated levels of emergency procedures or greater numbers of persons seeking elective surgery than had been forecast. The point we wish to stress is that the scope available to governments to deal with these kinds of situations should be seen as at least partly a function of public confidence. If there is confidence in the system, then decisions taken within it may be received as legitimate even if unpalatable. Conversely, if there is a lack of confidence, then decision making will take place in an environment in which public (and non-government political) response is both critical and insisting on more resources, something which has characterised the years since the current reforms were introduced.

6.4.7 A reading of the "Sustainable Funding Package" report shows a relative lack of confidence on the part of its authors in the ability of the public to accept limits, or understand the need for trade-offs. Its only reference to consultation is an

assessment of the outcome of consultation to date. At page 19 the report states "RHAs have a duty to consult with their communities and affected parties before they make any decisions which could significantly affect conditions of access to services. Consultation has shown that the predominant concern of communities is to maintain current conditions of access to existing services, rather than to support reconfigurations and re-prioritisation - even where these would lead to improved delivery arrangements and health outcomes."

6.4.8 This assessment assumes that the outcomes are a consequence of public attitudes rather than of the means of consultation adopted. There is a major difference between consultation or public debate over a specific service, with its emphasis on the level of resources needed to meet some ideal state of performance, and consultation over how to allocate scarce resources amongst competing services. The former, almost inevitably, takes place on the assumption (at least from the side of the public and non-government political interests) that the matter for debate is the level of additional resources required. The focus of the latter type of consultation, could it be achieved, should turn more on allocation as between different services. In particular, it should allow a focus on how to obtain maximum health gain, for the community overall, from a given level of resourcing.[12]

In MDL's view, a shift towards the latter emphasis in consultation, difficult though it may seem, should be an essential part of any strategy to manage fiscal risk. Consultation on a service by service basis will inevitably attract the greatest input from those (whether providers or consumers) who have the greatest stake in additional resourcing. Consultation with a focus on how to allocate scarce resources among competing demands has the prospect of giving people some understanding of the need for tradeoffs.

6.4.9 There is evidence that this can be achieved. A UK study "Voices Off: Tackling the Democratic Deficit in Health"[13] cites an example which shows that the public may

[12] The role of the National Health Committee should be noted here. The NHC provides independent advice to the Minister of Health on health priorities, and has made professional and community debate on health priorities a central feature of its work. See paragraph 5.2.3 above. See also paragraph 7.1.21

[13] (1995) Institute of Public Policy Research, London

be prepared to accept trade-offs **if they have the information needed in order to make an informed judgement.** The report states (page 97):

> *"Research into surveys of public opinion about health service priorities in Hackney demonstrated the familiar public concern to reduce mortality, whatever the success rate, or cost, of highly interventionist procedures. By comparison, informed public health opinion favoured population approaches which reduced morbidity. The Hackney survey showed that when supplied with further, relevant information, the responses of the two groups corresponded more closely. This indicates the importance of the educational role, which is implicated in any democratic process"*

6.4.10 The "Sustainable Funding Package" report provides a series of recommendations for the future of health sector expenditure, with its principal focus on improved incentives, controls etc within purchaser and provider groups. In respect of the public, the emphasis is on "managing public expectations" and on building public support through marketing with confidence the appropriateness of the resource decisions made for health.

6.4.11 The approach is one which, substantially, rejects any role for the public in consultation on health services priorities, either at the macro or the micro level. Instead, preferences are to be determined (presumably) through such things as market research techniques and the resultant decisions marketed "with confidence". We understand that, in practice, the role of consultation was not part of the brief for the "Sustainable Funding Package" report. We simply make the point that, in our view, sustainability requires public acceptance that the level and distribution of resources, and the decision making processes sitting behind that, are legitimate and that public involvement is an essential part of achieving legitimacy.

6.4.12 As the report itself recognises, the history of health services expenditure in New Zealand has been one of periods of restraint followed by ad hoc relaxation as political pressure comes to bear. Such pressures operate outside the bureaucratic system and are fed by a lack of any sense of ownership or responsibility for agreeing policy outcomes.

6.4.13 There is a need for managers within the health system to assess the costs and risks associated with public consultation against the potential for their controls and funding restraints to be set aside as the result of political pressure from a public or series of publics (special interest groups) which believes that their concerns are not being properly recognised.

6.4.14 The magnitudes of expenditure on health are such that substantial investment in public consultation may be justified simply as a risk management mechanism, that is, even if managers believed that they would not obtain any additional useful information from that investment. In practice, empirical evidence suggests that they would; we are simply making the point that a greater emphasis on effective

consultation (assuming that appropriate mechanisms can be devised - see section 7.2 below) will itself be worthwhile to the extent that it enhances public confidence in the system and lessens the risk of political pressures for additional funding arising from a sense of non involvement.

6.4.15 The concern is real, current and recognised at a political level. In an interview on National Radio on Wednesday 9 April the present Minister of Health commented "I've spent a lot of time talking to consumer groups since I have become the Minister and the most cutting remark that's been made to me is, why don't you stop talking about us and start talking to us?"

7.0 OPTIONS FOR PUBLIC INVOLVEMENT

7.1 NEW ZEALAND AND INTERNATIONAL EXPERIENCE

OVERVIEW

7.1.1 Enhanced public involvement and user influence has been gaining ground as a significant theme in major reforms in government services internationally, over the last decade. Both in New Zealand and overseas, especially in OECD countries, various forms of public involvement have been seen as a component of better quality government, and hence quality of outcomes, at two levels: improved policy and decision-making; and improved service delivery. In New Zealand public sector reform there has up to now been more emphasis on accountability than on public involvement as such. These are fundamentally different things. But in New Zealand, as much as in other parts of the world, there are pressures not just to change the way public services function, but to reconsider the way they relate to society.

7.1.2 Wherever this is occurring, we are seeing efforts to refine the processes of public involvement and to manage public expectations of government service delivery more effectively. There is a diverse body of New Zealand and international thinking to draw on. The literature describes numerous ways health authorities around the world have gone about seeking community input[14]. Thinking is becoming more precise and methods more effective, as the level of understanding of what works, and the conditions for effective public involvement, increases.

7.1.3 To begin, a number of broad common themes can usefully be identified.

- First, a common factor in bringing an explicit focus to public involvement has been recognition that not all government reforms, in themselves, lead automatically to enhanced public accountability or to effective programme outcomes. Contracting models in themselves have had more success in achieving efficiency and value for money than they have in meeting citizen and user interests, and have by nature tended to give most attention to provider relationships: a supplier-driven approach. Recognition of this is one reason we are seeing in New Zealand and overseas the emergence of conscious and planned approaches to public and user involvement, across central and local government.
- Also common to ongoing reform processes in New Zealand and elsewhere is increasing recognition of the importance of the distinction between *choice* and *voice*. Choice, ie the ability to exit and go to an alternative service, enhances public and user influence, but is typically a characteristic of market situations. Government social services are more often monopolies, or at least feature only limited market-type mechanisms. The lack of the option of user 'exit' therefore makes voice a far more important consideration.

[14] See literature review in Nuthall, op cit footnote 3. Nuthall usefully draws also on consultation and participation processes being developed in the environmental area in New Zealand and overseas (pp 24-27).

- Government agencies in many countries have adopted for themselves the private sector concept of ‘customer focus’ as a driver of management style. Even in the absence of direct market competition, the underlying rationale of competition, with the disciplines and benchmarks it demands, has increasingly informed management thinking in government services. Hence the adoption of mechanisms to achieve customer input and customer satisfaction such as the citizens’ charter, notably in the UK, and other means to ‘put customers first’, such as the service standards approach taken in the USA Government’s National Performance Review. These are by nature people-oriented approaches to the management of services.

  The community and customer focus (and the link with both to market research) can be mapped against community and commercial objectives as follows:

- There are signs of a shift towards public/user involvement as a contributor to the achievement of strategic and organisational objectives, in contrast to the past and still-current focus on compliance-driven consultation. This is, for example, seen in recognition of the role of consultation in securing a better public understanding of the constraints under which government services operate. It is also driven, independently, by the emphasis in modern management philosophy on the need for all the activities of the organisation to add value to the business, and in turn to meet owner/shareholder interests. In the case of government services, public involvement can also be seen as having the potential to contribute to meeting state ownership interests, most particularly managing the fiscal risk interest.

7.1.4 Cutting across these common themes is that in all countries where public involvement has become an issue, and as highlighted in Section 4.0 above, the most immediate imperative to address the issue has been the shift from the relatively relaxed management of resources capable of meeting most demands, to an intense concern with the allocation of limited resources among competing demands. Around the world, as within New Zealand, the different sectors and agencies of government have responded in widely diverging ways. As will be seen in the following material which sets out to describe the more significant developments

and experiences domestically and overseas, the different approaches diverge both in terms of objective, and in terms of technical design.

7.1.5 Because of the diversity of approaches, and because of natural variations in other factors critical to success (such as commitment, and quality of implementation), it follows that degrees of success have also varied. The international literature suggests that even the more acclaimed successes need to be viewed with some reservation, and that overall it is hard to find examples that could be considered fully tested and refined. This caution needs, however, to be put in the context:

- first, of the burgeoning level of public involvement activity;
- second, the attention being given by public authorities to improving tried mechanisms and to trialling new ones, an evolutionary process;
- third, the complex issues surrounding public involvement in service planning and delivery (especially in health care); and
- fourth, the fact that, certainly in New Zealand, public authorities and public agencies are still in the relatively early stages of culture and organisational change, and still learning new ways of managing.

It would be fair to say that the expectation should be improvement, not perfection. That sets a realistic goal for learning steadily from wider experience with public involvement in New Zealand, and from international models. In the absence of any international experience that proves any single superior path, some degree of experimentation and on-going evaluation will be necessary.

SIGNIFICANT DEVELOPMENTS AND EXPERIENCES: NEW ZEALAND AND OVERSEAS

7.1.6 Three sorts of distinctions need to be made to give some sort of framework to presenting and evaluating the different routes to public involvement:

(i) The distinction between the five elements of:

- information dissemination (eg published quality standards, public relations campaigns);
- consultation (eg public consultative processes);
- participation (eg through community advisory groups);
- partnership in decision-making (eg through representation on decision-making bodies, or fully devolved decision-making power);
- public pressure leading to political intervention as a means of “correcting” the perceived failure of government institutions to meet public needs. We do not deal further with this element except to note that it is part of the context within which management of the health system takes place.

Presented in this order, the first four elements represent increasing degrees of public/user influence:

(ii) The distinction between public involvement in:

- strategic policy;
- service planning and delivery;
- service development and design.

The CRHA's interests in community input encompass all three of these levels of health purchase. The statutory requirement to consult on strategic intent on purchasing and service planning and delivery is given over entirely to the RHAs. The Ministry of Health has a statutory requirement to consult only on public health. The National Health Committee is required to consult for the purpose of advising the Minister (see paragraph 5.2.3 above). CHEs and other providers have a contractual obligation to consult.

(iii) The distinction between public involvement and user involvement. Users in turn divide into consumers and providers. Consultation with providers is an important part of the management of the health system, but our brief for this report concerns public involvement and confidence. A link might exist between the facets of 'public' and 'provider' if there was a public perception of a deficit in provider input.

Other distinctions can be made within these broad categories, which bear on choosing successful strategies. An important example, referred to in paragraph 5.2.18, is differentiating between consultation and communication.

7.1.7 The following table summarises the more significant mechanisms by which government agencies internationally have sought public involvement in service planning and delivery. In paragraphs 7.1.8 to 7.1.24 , each of the mechanisms is described, with some commentary on their relevance and success or otherwise. We have concentrated on those most relevant to policy, service planning and delivery. Polls and surveys are not covered (see paragraph 1.3 above).

The four categories shown in the table are a useful way of mapping options, broadly scaling the different forms of public involvement according to degree of involvement, and going some way to matching the objective of public involvement with the choice of mechanism. Some mechanisms could fit equally well in one of the other categories, depending on the particular way they are designed and applied.

The mechanisms we have identified represent a broad spectrum of possibilities each of which offers insights into this complex area and from which, in Section 7.2

below, we draw options we believe are realistic ways to advance the CRHA's public involvement objectives.

Routes to Public Involvement in Service Planning and Delivery

Information (right to know and influence)	*Examples*
Citizens' charters	UK
Published quality standards	USA
Public information campaigns*	

Consultation (statutory, discretionary)	*Examples*
Voice (public meetings, submission processes etc)	Local government annual plans
Citizens' juries	WCC (Capital Power)
Polls, surveys*	
Complaints and advocacy procedures	Health and Disability
Commissioners	Health and Disability

Participation (expectation of community influence)	*Examples*
Community customer advisory boards	NZ: power companies
Service advocacy	Wanganui Health Task Force
Citizens' referenda (non-binding)	NZ: Capital Power (sale)
Citizens' parliament	Oregon: Citizens Health Care Parliament
Technical rationing with public input	Oregon Plan
Pluralistic bargaining/consensus	NZ: Core Services Committee

Decision-making (partnership, democracy)	*Examples*
Direct representation (elected membership, other)	Former area health boards
Citizens' referenda (binding)	NZ: compulsory superannuation
Community-based delivery* (including co-production, user co-operatives)	Iwi programmes
Community planning/delivery models:	
– Healthy Cities	7 NZ cities
– Safer Community Councils	57 NZ-wide

*These are not discussed below, being outside the brief.

Information

7.1.8 Citizens' Charters

Citizens' charters are a response primarily to the drive for improving the quality and responsiveness of public services. They are primarily performance guarantees, and hence are about customer service, based on the philosophy that services that remain in the public sector should provide a level of service as high as the best private sector organisations. They typically include as key principles the need to hear and heed the users' voice in setting service standards, and typically go hand in hand with de-centralisation to the most local level possible.

In these respects, charters are usually concerned with the service providers. They do not as such say anything directly about the role of purchasing authorities in influencing services. They are, however, of interest to purchasers in two regards. First, they provide one means by which the purchaser can be assured of customer confidence, and by inference, wider public confidence, in the quality of services delivered. Second, they can be adopted by the purchasing authority itself, as a means to govern its own relationships with community and consumer interests.

Citizens' charters are found in one form or another world-wide. The UK Citizens' Charter introduced in 1991 is the most comprehensive national approach of this kind. Comprehensive charters also exist in Belgium, France, Portugal, the USA and Canada. Similar initiatives have been taken in Hong Kong (Performance Pledges), Malaysia (2020 Programme) and Colombia ('It's A Deal' programme), to name a few.

In New Zealand there has not yet been much use made of citizens' charters. They are though emerging under the title 'customer charters' in the electricity distribution sector, but as a voluntary strategy being adopted by individual energy companies, and not as a result of a statutory requirement as is the case in the UK. In one case, TransAlta New Zealand Ltd, the process is being negotiated between the company and a customer advisory board, again adopted on a voluntary basis. Although it is yet too soon to assess the effectiveness of this approach, and especially the voluntary as opposed to statutory basis, early signs are that it is dealing in quite a robust way with service issues of real concern to consumers. It seems likely that factors influencing this include:

- The political sensitivity surrounding the industry and, in particular, the sense that government regulation may be invited unless there is a perceived improvement in public, especially domestic consumer, acceptance of company performance.
- The involvement of a semi-independent customer advisory board (board members are selected by the company, but from nominations put forward by third parties) is imposing a measure of discipline on the company.

MDL was involved in discussions with TransAlta on the merits of introducing a customer charter. One point which we made to the company (but which it had

already reached independently) was that customers were not the only audience for a customer charter. The charter also had the potential to be a very important document for agreeing with company staff the standards which should be expected of them and thus to become a key part in bedding in a customer-focused culture and setting a basis for ongoing increases in standards of performance.

Four particular features of the UK charter initiative have been that:

- charters for public services are mandatory;
- it is backed by a Citizens' Charter Unit located in the Cabinet office whose role is to ensure principles are put into practice by all public services;
- standards have had to relate to things customers care about, not to internal management standards;
- it includes user choice as a key element, assumed to be one effective way to enhance user influence and confidence.

A government review of the UK initiative in 1996, *The Citizens' Charter - Five Years On*[15], reported that 42 national charters had been established covering all key public services, and more than 100,000 local charters representing a high level of localisation. Charters have also been applied, compulsorily, to selected privatised monopolies such as power and water. The National Health Service was one of the three original priority areas for the Charter Unit (along with schools and British Rail). As in some other cases, in health a national Charter provides an umbrella of overall standards, with additional standards being set at the local level. The Patients' Charter was launched in 1991 with the objectives for the NHS of: listening and acting on people's views and needs; setting clear standards of performance; and providing services which meet those standards.

Measured in terms of improvements in standards (quantitative standards such as telephone answering times, trains running on time and hospital waiting lists, and qualitative standards such as courtesy to customers) and in customer satisfaction, the results across the board have been generally positive.

In respect of the UK Patients' Charter, reservations about its value have primarily been about how well the Charter addresses the problem of reconciling public expectations of what public services should provide, with the need to constrain costs. The Patients' Charter has focused on provider performance against standards which have more to do with how the service was delivered than with what gets delivered. People tend to care more about getting an operation and being cured (i.e., the outcome) than about their experience in the process. The Charter has been criticised therefore for focusing in the past on the wrong target.

In defence, its proponents argue that dealing successfully with the 'how' more clearly reveals the 'what' questions. But there is also a move now by the Citizen's

[15] CM 3370, September 1996.

Charter Unit to shift the focus from processes to outcomes. In the health sector, the 1996 Charter White Paper included a commitment to "pilot and evaluate a range of indicators aimed at giving patients better information about the quality of their treatment". Clinical indicators are being piloted. This work is seen as a first step towards giving patients the sort of information they want on clinical quality. The Labour Party Manifesto for the recent (May 1997) General Election included a commitment that a new patients' charter would concentrate on the quality and success of treatment.

It is also worth noting that the Patients' Charter in the UK has provided a platform for furthering the relationship between Community Health Councils and purchasers/providers.

A further issue has been the experience with rising consumer expectations as a direct result of charters. There is pressure to keep raising standards (*The Citizens' Charter - Five Years On* report contains over 100 new commitments to raise standards over the next 5 years). Further, and not surprisingly, the consequence of telling people about the standards they are entitled to has been to make them more confident about complaining. There are signs that the latter trend has resulted in a shift in attitudes among both providers and consumers generally.

Other issues with the UK charter approach have been the lack of citizens' redress for non-compliance in all but a few services; the risk of shifting the onus for redress on to the individual consumer, the provider thereby able to avoid dealing with consultative or representative community groups; and the relevance of standards to consumers in different situations (failure to meet a particular standard may be crucial to one person, and a mere irritant to another).

On this last point, efforts are being made to promote more consumer consultation over the selection and setting of standards. All new and revised charters in the UK must demonstrate that users of the service have been consulted on the standards and type of serviced offered, and that their views have been taken into account. From April 1997, all new and revised charters have had to be issued in draft, so that users' views can be taken into account before the final versions are published. (The Charter Unit is also issuing guidance for local services on producing charters which highlight the importance of consulting users and outlines the various methods that might be adopted.)

7.1.9 Published Service Quality Standards

These may be part and parcel of citizens' charters, and are integral to the UK Citizens' Charter. But statements of quality standards can also be instituted without the full machinery of the UK approach. In this case they will represent public statements, in quantitative and qualitative terms, of standards of performance, and can be seen as a shift from the traditional formal accountability for performance to Ministers and Parliament to more open accountability. In the USA, the National Performance Review's *Putting Customers First - Standards for Serving the*

American People (1995) is more towards this end of the spectrum than the full charter approach.

While the focus is on managing results and organisational performance (best practice benchmarking is one of the latest developments in the US National Performance Review), there is also an explicit intent to raise the transparency of public confidence in public services, increase responsiveness to citizens and improve outcomes for the community. These are seen as ways to earn confidence.

Service qualities covered in the service statements of those US public agencies which have joined the *Putting Customers First* initiative range from the general to the quite specific, and include, as examples, local overnight delivery (Postal Service), speed of telephone answering (Social Security Administration), fair market pricing (purchase of disability services), claims processing (Medicare and Medicaid) and how customer satisfaction will be measured (again Medicare and Medicaid).

A factor differentiating published service quality standards from citizens' charters seems to be the extent of consumer/community interaction. The US *Putting Customers First* initiative does have a strong component of "asking your customers", but the methods used appear to be more of a technical research nature (focus groups, surveys, etc) and less the shared user/provider viewpoint towards which the UK citizens' charter is evolving.

Consultation

7.1.10 Consultation in some form by public agencies is now extremely prevalent world-wide. It is well entrenched, in principle, as a political and management imperative; and is manifested, in practice, in the incorporation of consultation mechanisms into formal strategies and protocols.

Common to developments in New Zealand and overseas is to see the intent of consultation as providing for dialogue between public institutions/agencies and citizens/clients:

- for the public at large, a chance to express a viewpoint on future plans for services or on specific issues with significant implications for the public interest;
- for users of services, a choice to have an input into policy and programme decisions about new services or developments in existing services or delivery practices.

Of the three most frequently quoted reasons to consult - to meet legislative requirements, to gather information to enhance decision-making and to give the public more say in the decisions that affect their lives - it is the first which up until recently has dominated approaches taken by public authorities and agencies in New

Zealand. This is at least as true of the health sector as of any other area of public activity.

7.1.11 New Zealand Experience

New Zealand has developed its own unique statutory/common law framework for public consultation. Accordingly, we concentrate on New Zealand experience in terms of discussing formal processes.

- Section 5.1 above provides an overview of consultation under the Health and Disability Services Act 1993. Consultation under that Act in fact takes place within a framework which has been substantially developed under other legislation.

Local government consultation

Most experience with statutory obligations to consult has been within local government. A requirement to follow what is known as the special consultative procedure was introduced as part of the 1989 reforms to the reporting and accountability requirements for local government[16]. It was seen primarily as a mechanism to enhance public accountability. It applied mainly to annual plans which the 1989 legislation required local authorities to prepare and make public, but also extended to certain other major decisions such as the corporatisation of a council activity or the sale of a controlling interest in a local authority trading enterprise.

The local government legislation is more specific in its process requirements than is the Health and Disability Services Act. Local authorities are required to:

- Give public notice of the proposal;
- Allow a period of not less than one month, nor more than three months (unless the local authority directs otherwise) for written submissions to be made;
- Give people, making written submissions, a reasonable opportunity to be heard by the local authority;
- Make all written submissions available to the public;
- Make the final decision in relation to the proposal at a meeting of the local authority (the point of this is that local authority meetings are open to the public).

In its first review of public consultation in the annual planning process,[17] the Department of Internal Affairs expressed high hopes for the change:

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[16] Interestingly, the statutory provision does not actually use the term "consult" but local authorities have typically acted as though it did.

[17] Public Consultation in the Local Authority Annual Plan Process, Department of Internal Affairs, Wellington, 1992

> *"It is the added dimension of public consultation which makes the cycle of annual plans and annual reports central to the concept of local authority accountability. Authorities are now required to find out what their electors want before they make major decisions. For the first time the potential exists for a structured dialogue between councils and their public."*

Experience within local government has varied widely. Some local authorities have run upwards of 20 consultations a year, taking the view that they should be more open and seek community input whenever a major decision/policy initiative is underway.

Others have kept their consultation to the minimum required by the Act, that is, the statutory annual planning process and any corporatisations or asset sales where a statutory obligation has applied.

There is a growing acceptance within local government that there is a need to distinguish between "compliance" consultation and effective communication. Public awareness of the relatively few changes made to annual plans as a consequence of consultation has, in a number of cases, given rise to scepticism regarding the intentions of the local authority. There is something of a feeling that consultation is just a charade as the local authority intended to make its decisions anyway. In order to address this concern, local authorities are looking, increasingly, at various forms of dialogue with their communities before they release formal consultation documents, in order to determine public preferences and fine-tune their proposals.

At the same time, there are contrary currents running through a number of councils. These include:

- A growing concern from the public that it is being "over consulted" reflecting the cost in terms of time, effort and money involved in developing responses to detailed consultation documents (we note that we have just received a copy of the Porirua City Council's draft 1997/98 annual plan; it runs to 241 pages);
- Some citizens are saying to their councillors that they were elected to govern and why don't they just get on and do it.

In coping with these contending trends, local authorities are realising that their residents have different priorities and perspectives so that their views need to be established through the use of a variety of mechanisms. Some people will be content with relatively passive mechanisms; others will want active involvement. Amongst the strategies being used are:

- Quite detailed customer satisfaction surveys (in a sense these can be seen almost as the equivalent of a customer charter as they cover performance standards across a very wide range of services and, in some cases, to quite a level of detail). Particular stress is placed, in using these, on year by year changes;

- Recognising their limitations, councils are nonetheless using techniques such as focus groups.

Partly as a consequence of new financial management legislation, and the pressure that will place on formal decisionmaking processes, a number of councils are also considering means of holding dialogue with key stakeholders as part of the process of developing their main planning documents.

The shift to the use of various techniques outside the formal statutory consultation process also reflects another realisation within local government. This is that the best time to establish the legitimacy of your process is not when you are also seeking to consult on an issue which requires the use of a legitimate process. Rather, it makes better sense to have taken initiatives to establish the legitimacy of your process well before the time at which you need to use it. Then, when you need to bring potentially controversial matters before the public for consultation, you can at least do so in the knowledge that the legitimacy of your process is accepted.

This does not necessarily mean testing the actual process itself. It does mean having established a pattern of "fair dealing" which your public recognises as demonstrating good intentions and a commitment to taking their input seriously.

As a generalisation, there is widespread recognition within local government that existing consultation mechanisms are still far from perfect. Local authorities recognise that the real purpose of consultation is not just to avoid judicial review; it is to get as clear an understanding as they reasonably can of the preferences and priorities of the communities they govern including, as far as possible, an understanding of how those preferences and priorities differ. There is a recognition that, especially in a time of constrained resources, best results are obtained by working in harmony with the people whom the council serves rather than seeking simply to impose decisions on them. In this respect, the local government sector is ahead of central government.

Also in this respect, local government practice appears quite different from that typically followed by central government. There is sense in which local government recognises that it is much closer to its public than is the case with central government and its institutions. It is probably this factor, rather than any superiority of insight into the benefits of consultation, which has seen local government make much more effective use of consultation than is normally the case with central government agencies.

That said, it is also necessary to acknowledge that the issues on which central government agencies are required to consult (such as setting priorities and planning services within the health system) are inherently much more complex than most of the matters on which local government is required or chooses to consult.

Three examples: Wellington City, Wanganui City, Christchurch City

The only comprehensive overview of local authority consultation practice is the surveys which the Department of Internal Affairs carries out reviewing public consultation under the annual planning process. This is a brief statistical overview which is of limited value for the purposes of a project such as this. It concentrates on issues such as numbers of submissions received by individual local authorities on their draft annual plans and not on the broader issue of what kinds of consultation mechanisms might a local authority have used and with what assessed results.

To give some understanding of the developing experience within local government, we look at examples taken from three local authorities: Wellington; Wanganui and Christchurch. We do so noting that each of these three local authorities (and for that matter, every other local authority as far as we are aware) will emphasise that it is still on a learning curve regarding what works and what does not work in public consultation.

Wellington City has been moving from a relatively compliance focused approach to consultation to a much more inclusive one. Its early draft Annual Plans were written simply to meet the specifications of the Local Government Act. The City undertook relatively little other public consultation except on matters where there was a statutory requirement (such as the sale of significant corporate interests).

Particularly in the present triennium, the city has been searching for different means of involving the public more in its decision making processes and making itself more open to the population it serves. As examples:

- It has adopted a customer focus to its dealings with the public. This goes well beyond lip service to realigning its interaction with the public with the intention, as far as possible, of giving people a sense that their needs are recognised and treated as important. As a practical expression of this, the Council has turned its telephone receptionists into a customer call centre. This is staffed 24 hours a day, 7 days a week, and supported with an interactive database which allows the call centre representatives access to, and the ability to interrogate, the Council's database as a means of enabling them to answer queries. Call centre representatives have also been given limited authority to make decisions in response to enquiries, thus being able to deal with many issues immediately. Although this is not strictly public consultation, it is part of a repositioning designed to give people the impression that the Council is working on their behalf and thus underpinning the other measures it is taking in seeking to build up the confidence which its community has in the way in which it operates;
- Over the past two years, the Council has been developing a strategic plan. This is not a statutory requirement, but rather something being done to facilitate the Council's own long term planning and its compliance with new financial management legislation now in place. A core element in the development of that strategic plan was the establishment of a series of focus groups across the city selected to be broadly representative of the city's population. Through an

iterative process, these focus groups gradually developed a set of twelve goals for the city which now form both the core of its strategic plan and the goals which drive its annual planning process;

- The Council has been willing to experiment with new approaches to consultation. As an example, it was the first, and so far the only, local authority to use a citizens' jury as a means of deliberating on a major strategic issue (the sale of the Council's remaining interest in Capital Power);
- Of particular interest for the issue of how to set priorities within limited resources, the City Council has taken a new and different approach in the development of this year's draft Annual Plan. Rather than simply set out is preferred proposals and invite comment, it has offered its citizens a series of options from which to choose supported by information on the costs and benefits associated with those options. This has included:
  - ⇒ inviting citizens to rank the Council's twelve strategic goals in order of importance;
  - ⇒ asking respondents to divide new initiatives into three groups; definitely do, no particular preference, definitely do not do. The request was supported by information on the average cost per rate paying property of each initiative;
  - ⇒ express views on whether new initiatives should be funded by increased rates, decrease in existing services, or increased user charges;
  - ⇒ choices between four different sets of options for further development of the City and six different means of allocating rates as between the commercial sector and the residential sector.

The focus of this part of the Council's Annual Plan is on seeking to share with its community responsibility for decisions on what activities the Council should be undertaking/increasing/decreasing and how it should fund its activities. This approach has been based on providing citizens with background information to allow them to assess the implications of the different choices available to them.

The Annual Plan document itself is reinforced by public meetings (not many, as these are not seen as a particularly useful means of input) and a Council newsletter to all households explaining the key points of the Annual Plan.

Although not direct, there is something of a parallel between this process and what a Regional Health Authority might be able to do in consulting on its overall purchasing policy.

Wanganui City Council is another example of a Council which has sought close community involvement in a major strategic exercise.

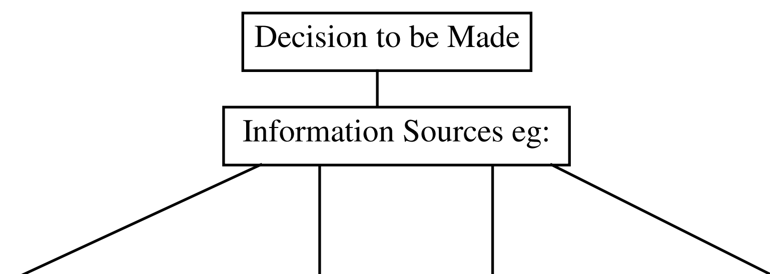
This Council, also, is seeking to develop a strategic plan. It has followed a six stage process:

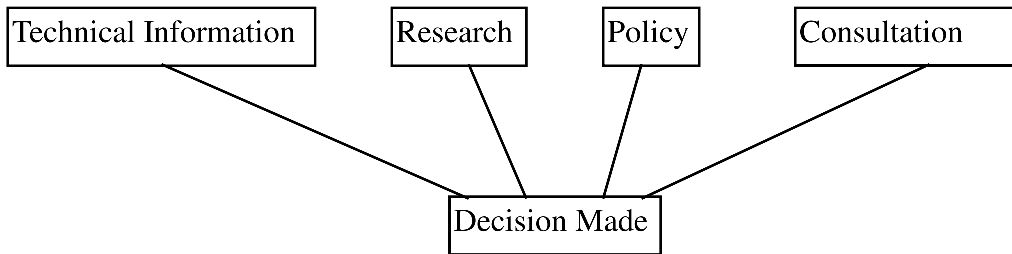
- Stage 1 - From research material, developing a variety of options, including advantages/disadvantages, costs and timing and drawing on strategic planning processes used by other public sector and by private sector organisations both locally and overseas in order to select a strategic planning option appropriate for the district.
- Stage 2 - Developing a series of briefing papers covering social issues, the environment, infrastructure, tourism and three economic sectors: primary, business and Maori business. Although there was a strong research input into these, focus group findings, questionnaires and discussion groups were an important part of drawing together views from across the community.

  The resultant papers were made available by the Council as background for the next stages in the process.
- Stage 3 - The future for the district was explored with 50 local people through four days of independently facilitated workshops. The people involved were selected to represent a cross-section of social, economic and environmental interests and were briefed on the findings of the Council's research before the workshops took place.
- Stage 4 - Using input from the first three stages, the Council developed a draft vision for the district and supporting documentation.
- Stage 5 - The Council is currently in the middle of this stage, which involves a range of means for seeking community input, including meetings with organisations and neighbourhood groups, encouraging all schools to participate in order to obtain views from the young people of the district, and encouraging submissions in writing, by phone (the Council is operating a freephone for this purpose) and through attendance at Council meetings.
- Stage 6 - On-going implementation of the directions/initiatives arising out of the strategic plan;

Throughout this process, the Council has maintained a commitment to the importance of community input and aligned its own internal processes to ensure that the experience of people taking part in the process reinforces the sense of commitment.

Christchurch City Council was one of the earlier city councils to recognise that a compliance approach to consultation would fall far short of what it needed. Its general policy on consultation emphasises the Council's role as decision maker and treats consultation as one of the major information sources to be fed into individual decisions.





Its approach to consultation places a heavy emphasis on considering matters such as:

- What is the nature of the decision which will result?
- Who will make the decision?
- Which parties, communities, etc., have an interest in the decision?
- What type of information do we require?
- What processes will best achieve our purposes?

There is a strong emphasis on flexibility, on clarity, on trying to avoid any mismatch between public expectations and the Council's commitment/process/resources.

Within that general approach, Christchurch has used a number of strategies, some long term, some decision specific.

It places a strong emphasis on understanding resident/ratepayer perceptions of council activity and how those perceptions change over time. For several years now, it has commissioned a detailed customer satisfaction survey which was designed and is implemented for it by the Department of Statistics. The choice of the Department was deliberate. For the Council it was important that this undertaking was seen to be objective and independent of the Council itself.

An understanding of the scope of its consultation activities can be gained from the following material from its own consultation guidelines setting out, respectively, "how" and "examples of consultation methods". See Figs 1 and 2.

Consultation with Maori

The area which, at the moment, seems to be the most difficult one for consultation within a local authority context, is consultation with tangata whenua, that is, with Maori as the treaty partner under the Treaty of Waitangi rather than with Maori as Taura Here. There are statutory obligations, under the Resource Management Act, on "all persons exercising functions and powers under it, in relation to managing the use, development, and protection of natural and physical resources:"

- To have particular regard to Kaitiakitanga;
- To take into account the principles of the Treaty of Waitangi.

Consultation with Maori as tangata whenua raises quite different issues from those involved in other consultation. They include:

- Local authorities are not party to the Treaty of Waitangi and there is an on-going issue between local government and the Crown as to who is responsible for the costs involved in complying with the principles of the Treaty;
- Local authority boundaries do not coincide with Iwi boundaries, thus raising particular difficulties in developing policies for the whole of the district;
- Resourcing of Maori input into consultation, especially in respect of complex resource management issues, has been a matter of particular sensitivity. Maori argue that they should not be required to meet the cost of ensuring that the principles of the Treaty are properly recognised but that, on the other hand, their rights should not be denied them simply because they cannot afford to meet the cost of proper consultation (this is most often the case where substantial cost is involved in investigating the history of a particular site or analysing the impact on Taonga of major developments).

A variety of initiatives have been trialled as a means of facilitating consultation with Maori. They include such things as:

- Recognition of Iwi nominees with expertise in Tikanga Maori and resource management (Auckland Regional Council);
- Establishment of Iwi liaison committees at a ward level after consultation with Maori (the Bay of Plenty Regional Council);
- A Maori consultative committee made up of combined representation from local Marae which meets about six times a year (Central Hawkes Bay District Council);
- A charter of understanding with the purpose to "develop a relationship of mutual benefit between Christchurch City Council and the Manawhenua Runanga of Ngai Tuahuriri";
- Establishment of a Maori committee as a formal committee of the Council comprising the Mayor, two councillors and 15 members appointed by Hapu, with a commitment to meet on at least 80% of local Marae each year (Wairoa District Council).

Local Government New Zealand is currently preparing the first overview of local government consultation with Maori, based on a postal survey of all local authorities.

7.1.12 **Voice**

The term "voice" refers to the range of ways in which people can take part in public debate and open forums with the public agency. The most commonly used methods are processes for the public to make and present submissions on proposed new initiatives or changes in service delivery, and public meetings where submissions are presented or an open debate is held. These means may also be used at the pre-planning stage, in order to identify concerns which may become issues to be addressed in the planning phase.

These sorts of means are used to consult the public, rather than to enable them to participate actively in decisions. Views expressed by the public may be over ridden in the decisions eventually taken.

7.1.13 **Citizens' Juries**

The concept of citizens' juries is to bring together a selected, representative panel of citizens to examine public issues, reform programmes, government plans, and social programmes. Findings are typically presented to the community at large.

The belief behind the value of citizens' juries is that they can generate public opinion that is both representative and informed. It is thought that average citizens, given the time and resources to learn about an issue, are capable of understanding complex arguments and making wise, well reasoned decisions.

A citizens' jury process will consist of two basic parts; - selecting a microcosm of the public to represent their community on the panel; - equipping the group to make informed decisions on the issue. Input comes from public hearings, at which the panel hears expert testimony and community view points. The panel will usually meet over a period of several days, and present their answer to the "charge" they are empowered to consider.

The Jefferson Centre in the U.S.A., a non profit organisation for researching methods of democratic decision making, has experimented with citizens' juries, exploring a wide range of pressing national issues which include heath care reform, welfare reform, at-risk children, federal and state budgets and elections.

At its best, the process can increase the level of trust between decision makers and the public. Unlike most public hearings, the panel ensures that average citizens conduct the dialogue. Citizens, rather than decisions makers and experts, sit behind the table rather than appearing as petitioners. Critical to the success of juries is that the jurors have enough time and resources to think things through, and that there is trust that the jury is operating in an unbiased setting.

A recent notable example of the use of a citizens' jury in New Zealand is the Wellington City Council's jury to consider the sale of its remaining shareholding in Capital Power. Preconditions for its success in informing the Council's decisions were absent. First, the Council did not have a well thought out intent in advance of

how it would respond to the outcome of the jury process. Second, and because of this, the public was led to hold false expectations about the influence the jury would have. People assumed the jury's recommendations would simply be accepted by the Council.

It seems unlikely that the citizens' jury process will be repeated in New Zealand in the near future. One of the prerequisites for success does seem to be the existence of a body such as the Jefferson Centre with the experience and independence needed to run an effective process.

7.1.14 **Complaints and Advocacy Procedures**

Complaints procedures in essence are a means for increasing organisational responsiveness to customer/user needs and wishes. Not only do they provide a channel for the individual to have a grievance resolved, they are also an important tool in risk management, identifying what the organisation needs to be doing better. To be fully effective, they need to be accompanied by:

- the prior establishment of accessible statements of consumer rights and of service quality standards. Complaints procedures are therefore quite closely related to charter and published service statement systems, discussed in paragraphs 7.1.8 and 7.1.9 above. The UK Citizens' Charter Unit Complaints Task Force for example has issued a Guide to Good Practice, signalling the integral role of complaints (and suggestions) systems in the Charter Programme;
- advocacy services, independent of the organisation, which provide informed advice to complainants on procedures and options, empower the complainant and possibly mediate between the complainant and the organisation.

The right to complain is one of the 11 rights specified in the Code of Health and Disability Consumers' Rights issued by the New Zealand Health and Disability Commissioner in 1996, the Code itself having been developed with extensive public input. If a consumer does not receive a service according to the rights in the Code, the consumer may lodge a complaint with the independent advocacy services set up by the Commissioner's office.

The New Zealand Code applies to the providers of services, not to the purchasers (RHAs). The CRHA nevertheless has established its own Consumer Complaints Policy and Procedures to apply to its own services (the location, range or nature of services available within its region, or the processes used by the CRHA to purchase them); and to complaints about providers that cannot be resolved at the complainant-provider level.

Benefits to public confidence and perceptions that can flow from well-managed complaints procedures include:

- simply that the consumer side of the relationship is taken seriously;

- demonstration of trust-worthiness, particularly the rigorous pursuit of a "culture of promise-keeping";
- the means to audit the performance of providers, reinforced by modelling an openness to complaints and feedback by the purchaser;
- a powerful source of insight and information for the improvement and planning of future services. (The UK Citizens' Charter Unit encourages public agencies to feed back into the development of charter standards the information which complaints generate.) To work, this would require the systematic collection and analysis of complaints data, as compared with just keeping records of individual complaints.

7.1.15 Commissioners

Independent commissioners are almost invariably reflective of a perceived need to address issues of public confidence in public (and in some cases private) institutions and systems.

The Health and Disability Commissioner is in New Zealand the example directly related to health. The Privacy Commissioner and Human Rights Commissioner are in a similar category.

The underlying principle of such commissioners is that providers should have their own systems for respecting people's rights. Commissioners provide a mechanism to promote and protect those rights. Commissioners generally work to improve relations between people and organisations (in health, between consumers and service providers). For this objective, they typically conduct inquiries in private. Their findings and perspectives do, however, enter the public arena, thereby contributing to public understanding of what can and should be expected of public/private institutions.

Paragraph 7.1.14 above describes the complaints and advocacy aspects of the Health and Disability Commissioner's role.

Participation

7.1.16 Community Advisory Boards

Community Advisory Boards are an official channel for public input into service planning and delivery.

Community Health Councils[18] in the UK have responsibilities which include: working closely with purchasers in identifying local needs; developing purchasing

[18] See pages 39-46 in "voices Off: Tackling the Democratic Deficit in Health", Institute for Public Policy Research, London

strategies and monitoring services; monitoring patients' charter activity from the patient's view point and helping to develop charter standards and goals; advising and supporting trusts in seeking patients' views and monitoring complaints; and playing a major role in supporting individual complainants.

The main responsibility for consulting Community Health Councils lies with purchasing authorities, although they are not obliged to consult if they consider it in the interests of the health service not to do so. Community Health Councils also have relationships with providers.

As with similar models elsewhere, the powers and capacities of Community Health Councils are somewhat limited. They have limited powers to hold health authorities to account, and are typically under-funded. Also in common with other similar models, there are wide variations in the way they work and how effective they are. Some are overwhelmed with demands from the health authority, while most feel marginalised. Some concentrate on helping individual users, while others work closely with purchasers. There are also variations in the level of representativeness of the wider community. And they face the difficult task of balancing detachment and involvement.

In the Danish model of user committees at the municipal and county level, the official objective has been to incorporate users as the sharers of responsibility for better public services. The idea is to strengthen the democratic element and increase efficiency in the political system. A common pattern across the sectors where user committees have been established is that they have little influence on the core service, ie the ideological and policy basis of services. Their influence has been more obvious on peripheral services. Nevertheless, user involvement and satisfaction is high. Causes of the limited influence of these user committees are in part structural: as elsewhere, final responsibility and powers with regard to decisions reside with the public agency. There are also cultural barriers, with different norms and values between the user committees and the public officials and professionals. In addition, there are time barriers in the form of the voluntary nature of committee work. This is seen as affecting not only the input a user committee can make to a particular issue, but also the ability of the committees to learn the rules of the game and how to exercise influence.

A key issue in the role of community advisory boards is the development of a closer definition of their role. Options are bodies whose authority is chiefly advisory, bodies who are co-producers with a high degree of authority with regard to decisions, and bodies which can exercise a control function.

New Zealand has not followed the UK pattern of making statutory provision for community advisory boards (as with the community health councils in the health sector or the customer advisory boards in the energy sector). However, there are signs that equivalent bodies will emerge on a voluntary basis, at least within monopoly industries. See the reference to the TransAlta New Zealand Ltd customer advisory board in the discussion of citizens' charters above.

7.1.17 **Service Advocacy**

This is a relatively new but potentially very significant development within New Zealand's local government sector. One consequence of the central government reforms of recent years has been a reduction in the access which individual citizens have to the decisonmakers on central government services. The most frequently cited example is the loss of elected area health boards and their replacement by commercially focused Crown Health Enterprises.

Area Health Boards were seen as having a brief to act, locally, to look after the health needs of their communities. In contrast, Crown Health Enterprises are seen as commercially tasked entities, reluctant to engage in debate or representation over service issues, and conducting their affairs under a cloak of "commercial confidentiality".

Other examples can be cited, for example, the loss of elected education boards.

One, almost certainly unanticipated, consequence has been a shift of focus towards local government as the body having the responsibility to represent the interests of its community to central government as a social service provider. As examples:

- We asked the director of policy of a major metropolitan authority why his council was taking a close interests in health issues. His response was that people had nowhere else to go so they came to the local authority and expected it to speak on their behalf.
- In a meeting with the mayor of a small rural authority we were told that he received at least one phone call a day regarding health issues.

This response has been both substantial and well-nigh universal. We doubt that there is a single local authority within the CRHA's region which does not see health advocacy as one of its roles. Most of them also accept a role as advocates in other social service areas.

This role should not be confused with an old style lobbying approach. Typically, when local authorities become involved in this way, they invest resources and apply quite competent policy analysts to dealing with the issues (indeed, a number of local authorities have commented to us that, given the complexity of much of the material to which the public is now expected to respond, in most communities the capacity to do so will only be found in the policy staff of the local authority). As examples of the kind of investment involved:

- Wanganui City Council made a substantial investment in funding a health taskforce to consider the community's response to a projected downsizing of the local Crown Health Enterprise. (Incidentally, the report of that taskforce includes the comment "unexpectedly, most submitters referred to the success of the health reforms in achieving efficiencies, better focusing on key roles,

accountability, cost effectiveness and in some areas the raising of standards", an interestingly positive comment given that the context in which the taskforce was established could have been expected to have a natural bias against the reforms.)

- Central Hawkes Bay District Council, recognised as a relatively "dry" council, established its own health taskforce with a grant of $30,000 and identifies health services advocacy as a core business of the council.

This process can be expected to evolve. Local authorities are recognising, increasingly, that their role is shifting beyond the conventional one of core infrastructural services and local recreation and cultural facilities towards one which more resembles that of governing the locality. A strong interest in quality of life is a natural corollary. It also reflects the increasing interest which most local authorities have in the quality of services within their district as a factor in their attractiveness as a location in which to undertake business. Lack of quality health care or poor educational facilities are now seen as quite directly a significant disadvantage for local economic activity.

The potential for such a role for local government is now gaining recognition at a central government level. In a recent address, the Prime Minister, the Right Hon J. B. Bolger, commented that "… the model for tomorrow may well see local bodies privatising non-essential services, becoming purchasers rather than providers of essential ones, and putting their energy into fostering civic participation in developing the strength of their communities"[19].

[19] "The Art of Association", address to the Annual Conference of the Auckland Division, New Zealand National Party, 4 May 1997.

7.1.18 **Citizens' Referenda (non-binding)**

New Zealand saw the introduction of legislation to provide for citizens initiated referenda (CIR) in 1993, described in the title to the Act as relating to:

> *"specific questions … the results of which … will indicate the views held by the people of New Zealand … but will not be binding on the New Zealand Government".*

A referendum must be held if an indicative referendum petition secures the signatures of not less than 10% of eligible electors.

Referenda have also been used by local authorities as a mechanism for consultation, as with Wellington City Council's referendum on the sale of its remaining shareholding in Capital Power Ltd.

Experience of CIR in New Zealand has already highlighted some interesting aspects of this mechanism for public involvement in decision-making. The positive benefits of CIR lie in their role in conveying to government a clear public view on a clear single question, and also, independently of the desire to influence government, in informing the wider community of the issue. The fire-fighters' referendum, perhaps the most publicised example, is significant for what it said about two particular aspects of CIR. One was that if the number of signatures obtained indicates a very high level of public support for the issue, and even though the CIR is non-binding, a Government may see this as pressure to act. Subsequent to the fire-fighters' referendum the Government decided to reduce the staffing cuts from the planned 20% to 1%. Second, the level of public support achieved will be a function of how well-resourced the organising group is, and how well it manages the process and especially media management. A question not yet settled in New Zealand is, what is the forum for negotiating a government response following a referendum.

Extensive overseas experience suggests a range of pros and cons which can be used to assess the usefulness of referenda for decisionmaking on resource allocation. In a survey of how direct democracy works in Switzerland, *The Economist* (21 December 1996) identifies the following issues for referenda (the study relates to binding referenda, but the issues are equally relevant to non-binding referenda):

- Participation - the historically relatively high turnout for referenda in Switzerland has declined to about 40% of the population through the 1980s and 1990s. This is a sign of loss of enthusiasm for this form of voting, in comparison with turnout on elections. It also appears that a fair number of referenda are the result of small groups of enthusiasts/minorities, which may turn other people off. Participation is higher when the referendum concerns a big decision than it is on "fiddling" issues.
- There is a concern that money can shape the outcome of a referendum. Studies in both Switzerland and in American states which use direct democracy suggest a

link between the amount of money spent on propaganda and the result of the referendum. This is not always the case, but *The Economist* notes that the connection between money and votes seems persistent enough to justify concerns. Two counter factors are the ability of voters to set limits on the amount of propaganda money spent on referenda; and the argument that money can just as easily distort traditional forms of democracy, and less visibly than in direct democracy. Under direct democracy, lobbyists have to target the whole body of voters. In a representative democracy the lobbyists' target is just members of the government and legislature. So to the extent that referenda are considered a 'rival' to elected representation, referenda may have equity advantages.

- Referenda have limitations when it comes to complex economic and social issues - how well can these issues be understood by ordinary people? It is also possible to ask the same question, however, of elected representatives and experts. Complexity characterises all decisionmaking at all levels in modern societies.
- Minorities may not fare well in a referendum-based system, particularly where turnout is low. Again, studies in Switzerland and America show that as turnout declines, disadvantaged minorities become a smaller proportion of the total, and better-off and better-educated groups become a larger proportion. This suggests that referenda are a more 'middle class way' of making decisions than parliamentary elections. It also suggests that for referenda to deliver fair outcomes, where the issue to be decided has particular implications for disadvantaged minorities, people will need to vote unselfishly.

In the whole area of citizen 'voting', the Internet is clearly going to have a huge impact on avenues for expression of voice - and indeed more generally. The Internet is potentially not only a cost-effective way for public bodies and citizens to interact, but can be expected to change profoundly how people communicate. In particular, it has the potential to deal with the limitations of present systems on achieving representativity.

7.1.19 **Citizens' Parliament**

In what seems to be an internationally unique initiative, a network of citizens in the state of Oregon, the Oregon Health Decisions, began a project in 1987 called "Oregon Health Priorities for the 1990s". The initiative involved extensive community meetings to discuss priority setting at different levels of health care. People were asked to consider the priority that health care should receive in comparison to other social needs, and to consider what general priorities should be assigned within the health care sector on the basis of pre-identified health care 'building blocks'.

Community meetings led to the appointment of 50 delegates to meet as a Citizens Health Care Parliament. The parliament passed a set of principles which included the principle, for example, that "allocation of health resources should be based, in

part, on a scale of public attitudes that quantifies the trade-off between length of life and quality of life". The full set of principles was published and sent to the state legislature. The result was that many of the principles became reflected in senate legislation on health. There have been questions raised, however, about the dominance of professionals among the delegates even though almost half were participants from the community meetings. Community representation therefore remains an issue despite the use of a "parliamentary" model.

The Oregon experience has its interesting aspects, but is not likely to have immediate application in New Zealand, mainly because the replicability of key aspects is open to question.

7.1.20 **Technical Rationing with Public Involvement**

Using technical frameworks for rationing has been a particular preserve of health economics and public health.

Technical bases for priority setting are able to incorporate methodologies for public input. An example is found in the Oregon Plan initiated in 1989 which was an ambitious attempt to resolve conflicts in health care provisions by explicit rationing. It was conceived as a solution to a particular problem facing the state regarding the widening of health care insurance to individuals presently uninsured while remaining within a fixed budget - the dilemma of "all for some or some for all".

The exercise began with the design of technical methodology, which it is not necessary to describe here. A key component of the methodology however was obtaining public preferences (social values) through public hearings, community meetings and a telephone survey, the results being then fed into a Quality of Well-being Scale, and linked with information about health outcomes to derive utilities. The public was not invited to rate specific conditions because of the competence required to make such judgments. The final step was for the Health Services Commission to apply professional judgements and their interpretation of the community values to re-rate out-of-position items on the draft list. The final priority list is therefore to a large extent composed according to the value judgments of professionals. This was justified by the shortcomings seen in the other methods utilised in the overall process.

The Oregon Plan attracted a great deal of controversy, to the extent that one of its successes has been seen as the volume of study it generated of technical methods for explicit priority setting. It has also however met with a considerable amount of interest for its potential elsewhere in the United States and in other countries (for example the UK and Australia) grappling with the problems of rising health care costs. In the UK, the Mid Essex Health Authority made selective use of the Oregon approach, putting more emphasis on the need for the public to be involved in assessing health priorities.

The Oregon Plan is probably more interesting for previously hidden issues it brought out than for the details of the plan itself. In particular, it exposed the fact that technical rationing may produce results which are unexpected and/or unacceptable to some. This happens because the nature of the priorities that will be set is not open to discussion prior to the formation of a priorities list. This contrasts with the more open nature of pluralistic bargaining, discussed below, in which a wide range of issues are inevitably discussed as part of the process by which priorities are set. An unintended but perhaps inevitable result of the Oregon approach was an overlay of political process on the technical process.

7.1.21 **Pluralistic Bargaining/Consensus**

The New Zealand approach to defining core services initiated by the Green and White Paper provides an example of ‘pluralistic bargaining’, a task which was assigned to the then Core Services Committee (now the National Advisory Committee on Core Health and Disability Support Services, the NHC). Drawing on the Oregon Plan experience[20], but in contrast to it, a consensus approach was adopted. Public consultation was a feature of each stage of the Committee’s work and included ethics forums for the public; public forums; public meetings including hui; consensus conferences with lay participation; a questionnaire for the public; and public documents with the aims of broadening the debate and acquiring information about public views on priority setting.

As a process for public involvement, it was suggested to us that, especially as it has since evolved with the NHC, the Core Services Committee’s approach can be regarded as having certain strengths. It has brought lay views together with clinical views to inform health priorities. More importantly, the process is regarded as being able to take people through the broad questions of why priorities had to be set, what priorities generally might look like - an ‘educative’ process - and then took consumer representatives through more detailed questions about when a service should be made available and to whom. The original Committee’s style was to say “let’s talk, let’s get a sense of general feelings and some general impressions”, and to generate some wider understanding of the complexities.

Dr Graham Scott, in an evaluation of the post-reform health system in New Zealand, suggests that the Core Services Committee should be perceived as public participation rather than as a key link in the system for health purchase decisions[21].

As a means for reaching a decisive view on core services, there is a real question about whether this or any other method (including the elaborate and expensive Oregon Plan) can in fact succeed, especially in the face of the power of the high-

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[20] The Committee’s approach to core services to some extent employed Oregon-style technical methodologies. The technical component is seen as necessary to give shape and direction to priorities which emerge from public input.

[21] “Government Reform in New Zealand”, Graham C. Scott, International Monetary Fund October 1996, p.102.

profile individual case. Experience world-wide is that whatever process is adopted, the final outcome is the same - the big questions of 'what services' and 'what access' remain. The present National Health Committee is following a path which starts with a core 'list' (services already funded) and works progressively through the fundamental policy issues in health choices.

The pluralistic bargaining approach raises fundamental questions concerning who should be involved in the bargaining process, and indeed how this decision itself should be made. It is a decision that may have huge implications for the priorities which subsequently emerge.

Decision-making

7.1.22 Direct Representation (Elected Membership, Other)

Direct representation through elections to a governing board has been a common means of providing what the public has seen as the assurance that their interests will be taken into account. The gap between perception and reality can be profound.

In New Zealand, one of the most obvious examples of this was the experience with area health boards and, before them, hospital boards. The boards were expected both to be accountable to central government for the expenditure of taxpayer monies and responsive to local demands for service delivery. The result was an inherent conflict which, all too frequently, was resolved in favour of local interests in response to the electoral imperative.

The most extreme example of this was the Auckland Area Health Board, whose inability to control spending resulted in the then Minister of Health (the Hon Helen Clark) dismissing the board and replacing it with a commissioner charged to bring its spending under control.

It is now widely recognised that one of the key requirements for the accountability of elected boards is that the resources they control are substantially provided by (or pre-empted from) the persons responsible for electing them. This is seen as a key nexus in the accountability relationship. Without it, there is little or no incentive towards managing resources efficiently.

Nonetheless, the demand for elected representation remains strong, especially in services as critical to well-being as health. This is reflected in the coalition agreement's commitment that "elected community representation will be considered by a joint working party of coalition MPs as to the most appropriate place for public representation in the health sector". It is a reasonable assumption that this provision was included in the coalition agreement because National and New Zealand First recognised the force (or attractiveness) of the argument that an elected component was essential for a responsive health system.

Experience elsewhere in the public sector also argues against the use of elected members and in favour of management under the control of persons appointed on the grounds of competence and experience, at least when dealing with special purpose bodies rather than ones with a general governing mandate.

7.1.23 Citizens' Referenda (binding)

Binding referenda are a form of direct democracy, the purpose of which is in part to compensate for the shortcomings in elected representation. In the view of optimists, another purpose is to encourage ordinary people to learn responsibility and shoulder more of the burden of government - to become better citizens. Another view of binding referenda is that voting directly on issues of the day is more efficient than delegating the decisionmaking job to elected representatives, because it goes more directly to what people want.

We have seen only limited use of binding referenda in New Zealand, the referenda on proportional representation and the forthcoming referendum on compulsory superannuation being two examples. They can only be initiated by government, and require special (one-off) legislative provision. The same issues as discussed in section 7.1.18 above on non-binding referenda apply.

7.1.24 Community Planning/Delivery Models

There has been an international movement towards mechanisms for community development and planning based on partnership approaches which bring together community groups, particular interest groups, local authorities, other public authorities, and in some cases central government. Typically, the development of the initiative itself involves active participation of all parties.

Two notable examples in New Zealand are Healthy Cities and Safer Community Councils.

Healthy Cities is an international initiative adopted by over 2000 cities and communities world-wide. Shared elements in the Healthy Cities concept are: equity in sharing resources; planning that centres on people; and respect for the natural environment. It is an holistic approach concerned with the development of healthy social, cultural, spiritual and physical environments through healthy public policy and community development. It involves a co-operative approach to health planning and urban administration. The aim is to enable people in the community to participate more effectively in decisionmaking, and to have those who make policy decisions work together. Healthy Cities is based on the Ottawa Charter for Health Promotion which includes a major emphasis on the re-orientation of health services, strengthening community action and developing personal skills.

In New Zealand there are seven Healthy Cities projects at various stages of development including Nelson, Lower Hutt, North Shore, Porirua, Otago, Masterton and Manukau. Taking as one example the Manukau Health City

initiative which sits within the Manukau City Council, the partnership process has produced: a three year plan; a charter formalising the commitment of each participating agency or group; and a raft of specific projects including a contract with North Health for a project planner for a youth needs project, a business-supported food co-ordinator, an assessment of housing needs and services, an injury prevention group, a government policy monitoring group and an employment network.

Safer Community Councils resulted from a crime prevention strategy launched in 1993 which recognised that government needs to be working in partnership with communities to find the best solutions to crime problems that exist at the local levels. Safer Community Councils have been established around the country, mostly sponsored by local authorities and some iwi-sponsored. Council membership normally includes representatives from the business, health and education sectors, key community groups, local iwi Maori and representatives from government funding agencies and crime prevention agencies. Most councils have a paid co-ordinator.

As well as improving the co-ordination of existing community crime prevention programmes, the role of councils is to facilitate the development of new initiatives that address service gaps in the community. A range of processes is used including getting community groups together to talk about activities and plan solutions, helping individuals access services and focusing resources to areas of most need.

There are already examples of Safer Community Councils working with Regional Health Authorities on community health issues. The two Lower Hutt councils, the Safer Community Action Network and Nga O Awakairangi, together with a local health provider, developed a proposal for post-natal services for high risk women which is being funded by the CRHA. The Crime Prevention Unit is funding the evaluation of the project.

Experience with these models varies considerably from area to area, often by design. In respect of the Safer Community Councils, some councils work jointly with central government agencies; others (Wellington City Council's initiative is the newest example) are specifically designed to provide a community forum to plan strategies for their community, with central government agencies as a second line; still others produce business plans which they look to central government to resource and implement.

7.1.25 Emerging Issues in Public Involvement

In the course of discussions we had with the range of informants we interviewed on their experience with community consultation, a number of emerging issues relevant to the more general question of public involvement and confidence emerged. These add to the backdrop against which any future options can be considered. Two we considered of particular interest were:

Cross-sectoral consultation initiatives

There is increasing awareness in the social service area of the importance of taking a systemic view of social need and how needs are met from the different services and agencies, particularly at the local level. This partly has to do simply with co-ordination - preventing gaps and avoiding duplication that will result in better use of resources.

An initiative by the Chief Executives of three major social policy departments to work with local authorities, and through that means with community groups, suggests a higher purpose, that of making links across the different interests of central and local government whose activities interact. The Chief Executives of the Department of Social Welfare and the Ministries of Health and Education recently joined in a visit to Waitakere for discussions with the Waitakere City mayor and others aimed at understanding each others roles and constraints, at the ground level as well as nationally. Discussions focused especially on the Waitakere City Council's strong approach to community well-being and the three departments' common concern with the over-arching issue of families at risk. The emphasis was on alignment of interest, not cost-shifting. A consequence of this initiative is potentially a great deal more sharing of information about what are the pressing social needs and the best way to address them from the different perspectives. The main benefit is seen to be capitalising on the collective capacity of all the parties to facilitate the community interest.

This example has some parallels for the CRHA, given the importance of co-ordination and role clarification with key providers on service planning and community input, highlighted by the experience with the Hawkes Bay Regional Hospital situation (see the discussion in paragraph 5.1.14 above).

A strategic focus

With accumulating experience with consultation, the tendency of community input to concentrate on and be bounded by specific interests and issues has been

increasingly highlighted. This tendency has been at the cost of understandings of the trade-offs that need to be made at the strategic level of deciding ‘who gets what’.

To a large extent, the cause lies with how the issues are put to out to community consultation. We were given the example of the local authority annual planning process which has dominated community input on resource allocation to council services, driven by legal requirements. As the discussion in 7.1.11 shows, local authorities have been developing a number of different initiatives for dealing with this. Here we note that the advent of strategic plans for local authorities is seen as a means of providing a platform for the public’s attention to shift from the short term issues in the annual plan to the longer term ‘bigger picture’, so that consultation on the annual plan can occur in the context of public understanding of the council’s strategic direction, and, importantly, of the trade-offs associated with setting strategic goals for the community.

Whether or not this shift occurs, and can similarly be made to occur in other sectors, depends on very good management by the body seeking to consult. The shortcomings in existing consultation that create public disillusionment need to be addressed if consultation is to move on successfully to strategic issues.

7.2 OPTIONS FOR USE IN NEW ZEALAND’S HEALTH SECTOR

7.2.1 Introduction

In section 1.2 we proposed that addressing the public confidence issue required:

- Developing processes which give the public an assurance that their voice has been heard at the point of decision making;
- Allowing the public to understand the need for tradeoffs in resource allocation and have a sense that these judgements are being made with an awareness of community concerns;
- Dealing the problem that consultation in a legal compliance sense fails to satisfy the public demand for involvement before firm proposals have been developed;
- Designing structural arrangements which answer the demand for representation without compromising the need for governance.

In this report we have reviewed a wide range of different techniques for public involvement. We have also seen that the CRHA itself has used a number of different approaches, the selection of which has depended on factors, including:

- The nature and scope of the issue;
- The extent and variety of the interest groups/individuals likely to be affected;

- The CRHA's evolving understanding of the boundary between its obligation to consult and the obligation of providers.

In our view, the issue of public confidence is not so much a matter of the selection of the specific means to be followed in any given case so much as the underlying structural and organisational context (including the culture of the organisation) in which consultation takes place. Selection of a potentially ideal means of consultation is unlikely to lead to a good outcome if:

- There is a mis-match between external and internal processes (for example the organisation fails to respond in a timely and understanding way to written or oral submissions);
- There is an absence of commitment within the organisation so that there is no follow-through;
- Internal co-ordination is lacking so that the public or other parties consulted receive mixed messages.

In the balance of this section, we first set out pre-conditions for public consultation and then review five options for public involvement, assessing them against the four objectives set out above. We conclude with some further comment on the relevance of the insights from the social capital/civil society debate.

7.2.2 Pre-Conditions

Earlier sections of this paper have stressed the importance of making appropriate provision for public consultation but they have also highlighted the fact that this is far from easy. New Zealand's experience with public consultation, especially the statutory model which has developed since the late 1980s, is that it can be difficult to manage, public expectations are frequently disappointed, and the agencies involved in consultation may find that, in effect, they are worse off than when they started.

There is something of this latter impression in the comment in the "Sustainable Funding Package" report that "consultation has shown that the predominant concern of communities is to maintain current conditions of access to existing services, rather than to support reconfigurations and reprioritisation - even where these would lead to improved delivery arrangements and health outcomes".

What can be drawn from New Zealand and overseas experience is that there are a number of preconditions attached to successful public consultation. Key ones include:

- First and foremost, putting time into building the processes of communication/consultation, ideally in advance of, but at least separately from, their use for any specific consultation. Techniques for doing this include active

ongoing communication of priorities and constraints, and building linkages with key stakeholders/influencers within your community.

- Establishing leadership, which means communicating commitment from the organisation, proactively creating linkages among the interested parties, clearly assigning a leader in the organisation with the mandate to act, and consistently good management of the whole process. Leadership also entails effective co-ordination among the different health agencies on consultation processes to establish a clear path for community and consumer input, and providing the sort of leadership that allows communities and interest groups to be part of the solution, rather than the problem.
- Not allowing consultation to extend to matters which you cannot change. To do so is simply to raise false expectations which will inevitably be disappointed, with a consequent loss of credibility on the part of the consulting organisation.
- Being clear about the subject matter of consultation. This means knowing what you are consulting about, knowing the boundaries which you wish to set around the consultation and making these clear from the beginning.
- Understanding the process you intend to follow and ensuring that the public whom you are consulting also understand the process (or at least have clear information regarding the process).
- Ensuring that the process is consistent, both externally in terms of consultation with the public, and internally, in two senses:
  - internal processes and skills are consistent with the external processes and can meet the expectations those are raising;
  - internal processes are properly co-ordinated so that there is no risk that consultation will falter or run into difficulty because of differing priorities within your organisation or conflict/confusion with other activities.

  This is more likely to occur when consultation and communication are, in Nuthall's words, "'everybody's business', part of the organisation bloodstream of purchasing activity …"[22].
- Treating the parties whom you are consulting with respect. This includes recognising that they are committing time and resources, usually at some personal cost; ensuring that submissions are properly and promptly acknowledged; and advising them of the outcome as soon as possible after your decision is taken. It also means being aware of the distinction between consultation that is a success in the eyes of those who control the process, and the satisfaction of the community and consumer participants.
- Ensuring that the people within your organisation, and any external to it who will have an influence over the decision you may take, are committed to the consultation process.

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[22] See footnote 3. Quote is from P. 18.

- Doing what you can to make the consultation process accessible and user friendly. This entails remembering that not all of your audience are trained policy analysts; and recognising and accommodating the existence of different cultures within your community.

REVIEW OF FIVE OPTIONS

7.2.3 In this part of the report we review five options for public involvement/user influence which we consider could contribute to the objective of further enhancing public confidence in the public health system. In accord with the comment in paragraph 7.2.1, the five options selected for review are all what could be termed "macro" level tools. Their purpose is to create an environment which will both enhance the likelihood of selecting the measures which best suit any particular initiative to involve public/users, and of building public confidence that those measures will produce outcomes which, even if unpalatable, can be seen as "fair" in the sense of being the product of a legitimate process. In respect of each option, we first outline the option and identify what we see as the principal issues associated with its adoption, and then assess it against the four objectives for public confidence set out at the beginning of paragraph 7.2.1. The options included are:

- Customer charter
- Customer advisory boards/stakeholder consultation
- Statement of intent
- Local government involvement
- Elected input.

In discussing these options, we are conscious that the structure of the health system itself is currently undergoing change. We have therefore made the following assumptions:

- Four regional health authorities will be replaced by one national funding agency. This agency will establish common policies in purchasing issues on matters of national concern but actual purchase will then substantially be delegated to four regional offices formed to replace the current RHAs.

- Crown Health Enterprises will be replaced by Regional Hospital and Community Services with the principal result being a shift from a requirement to operate as a "successful and efficient business" to one of being required to carry out activity in a businesslike fashion but in a context in which the Government's health policy "has the overriding goal of ensuring principles of public service replace commercial profit objectives". It is explicitly assumed that this objective seeks to encourage a more collaborative approach to the provision of health services including an openness to working with the communities served in order to determine their requirements for the delivery of the services for which Regional Hospital and Community Services are responsible.

7.2.4 **Customer Charter**

The overt objective of a customer charter is to set out, for the customers of the organisation, the standards and style of performance which they can expect and the consequences, for them and for the organisation, if those standards are not met. As noted above, a customer charter can also serve the potentially more important objective of aligning the organisation's culture and practice with its desired objectives for customer relationships/outcomes.

It is this point we wish to stress. The customer charter should quite specifically be seen as the organisation's commitment to the way in which it will operate. It should set benchmarks/objectives covering the range of activities/relationships which the organisation (or the Ministers to whom it is accountable) considers important in aligning its structure and internal processes with the requirements of effective consultation (much of this is covered in the pre-conditions set out in paragraph 7.2.2 above).

We do not favour imposing, either by statute or other means, a requirement that an organisation adopt a customer charter. We do favour encouraging the adoption of a customer charter as an element of good practice (we would expect any organisation which failed to adopt a customer charter to have strong and persuasive reasons in support of its decision and not simply be allowed to ignore this particular tool). We note that doing so requires the organisation to have a strong focus on matters such as:

- Who are our customers?
- What do we believe our customers expect of us?
- How can we test that our beliefs are correct or at the very least have operational value?
- What systems or practices do we need to have in place to underpin the kinds of outcomes we wish to offer our customers?

We also note that customer charters, if adopted, are likely to evolve quite differently at the level of the funder and the level of the Regional Hospital and Community Services organisations. The latter may conclude that their customers are the people who receive services from them and, given their regional focus, find it comparatively straightforward to develop a workable set of understandings regarding customer expectations. In contrast, the new national funding agency may find this significantly more difficult. In terms of aligning its organisation, its governing body may conclude that its customers are one or more of:

- The Minister and Associate Minister of Health (and possibly other Ministers);
- Current and potential providers;
- The communities on whose behalf it purchases services (however the term "community" is defined).

On the other hand, it may conclude that individual recipients of health and disability services are not customers in any sense which can usefully be reflected in a customer charter as it does not have and could not sensibly create a sufficiently direct and close relationship so that there were claims/expectations which individuals had of the funding agency and which should be used by the agency as performance targets/benchmarks, whether a charter were to be adopted at a national level or for each of its regional offices.

To deal with this, the charter may incorporate proxies such as the quality/nature of its relationship with key customer groups, local authorities, and other parties with a customer perspective.

The development of the customer charter would also link in with, and be assisted by, certain of the other measures we recommend. Each of the proposed customer advisory boards, local authorities within the area covered by the entity concerned (the Regional Hospital and Community Service or the regional office of the national funding agency) and the elected accountability body suggested in paragraph 7.2.7 below would have a role to play in developing customer charters.

In respect of the four objectives:

- A well drawn customer charter should focus specifically on ensuring the organisation's processes give the public an assurance that their voice has been heard at the point of decision making;
- It should also be focused on giving the public a sense that judgements are made with an awareness of community concerns. The charter should incorporate specific requirements/performance measures oriented towards this. It is less directly supportive of giving the public an understanding of the need for tradeoffs, but the processes it enables should support this;
- It should be quite explicit on consultation being more than just a matter of legal compliance;
- Although not strictly a representation device, an effective customer charter provides a part answer to the concerns which underly demands for elected representation.

7.2.5 Customer Advisory Boards

The term customer advisory board (CAB) is a relatively generic term for a group of people selected to provide an organisation with a representative cross section of their total customer base. The purpose is to have available to the organisation a body which can:

- Comment on strategy/policy/proposals from a customer perspective before the organisation has made a substantial commitment to a specific option so that the organisation can gain an understanding of likely customer response and factor that into its planning/development.
- Provide a channel for input on customer concerns.

CABs have the potential to be extremely effective but also require considerable care in their design and establishment and a high level of commitment to creating a favourable climate, within the organisation, for the role of the CAB.

Doing this is, in a number of respects, a delicate balancing act. The board must have credibility with customers but be acceptable to the organisation. It must have the ability to speak out publicly when it believes it needs to do so whilst at the same time gaining the confidence and trust of the organisation. It must be adequately resourced to deal with occasionally complex matters but not be seen as a drain on the scarce resources of the organisation. It must be seen as representative of customers but also have the experience and capability needed to deal with complex issues on their merits rather than from an emotive or special interest perspective.

In practice this suggests measures such as:

- Establishing clear criteria for the mix of membership and the skills/experience which, desirably, they would bring to the board. A particular difficulty in achieving this is balancing reasonable representation (by age, gender, ethnicity, geography, socio-economic status and particular health needs) with the need for an effective working body which suggests total membership of not much more than 7-9 persons.
- Membership should be by selection not election. Desirably, members would be selected from nominations put forward by bodies themselves seen as reasonably representative of the community being served with final selection being made by the organisation. Ideally, this means that the members of the board are put forward because the communities from which they come believe they are appropriate persons to serve in that role but the organisation has the final right to select so that it can avoid having imposed on it people whom it believes would be difficult to work with or who lack the necessary experience or qualifications.
- The board should have the understood right, through a nominated spokesperson, to make public statements on issues where it believes the organisation has failed to deliver or to deliver effectively, provided that it has first sought to work through the issue concerned with the organisation and has given it the opportunity of seeing the comments which the board proposes to release.
- There needs to be a clear understanding of the level of resourcing which will be available to the board and the range and level of activities which that is expected to support.
- Finally, there must be commitment within the organisation, from the board and chief executive down, to ensuring that the customer advisory board relationship works and that the organisation's own internal processes are supportive of this.

Again, as with the citizens' charter, we see immediate application for the CAB at the level of the Regional Hospital and Community Service organisation. The issue is a little more complex at the level of the national funding agency amongst other things because of the difficulty in establishing a reasonably representative body

which would still be on a sufficiently small scale to be effective as a working group. We note also that, at least in terms of theory, at the national level there is an argument that Parliament is, in effect, the customer advisory board for the health sector.

We do consider, though, that there may be merit in exploring the CAB concept at the regional office level. One issue which has consistently faced people working within the health sector is that there is no such thing as a competent health consumer group. There is a plethora of special interest groups within the health sector but these naturally focus on the particular service or set of services of interest to their members. Their focus tends to be on increased resources for their particular area of concern rather than on how to manage trade-offs, between different services and customer groups, in a context of limited resources.

Accordingly, at the regional level we are attracted to considering the idea of a customer advisory board whose major focus would be on how resource allocation decisions are made. We put this suggestion forward as we consider that one of the major difficulties within the health service at the moment is the lack of any mechanism for helping share with the community the responsibility, currently carried by government and health sector organisations, for making decisions on resource allocation in a situation of constraint.

Obviously, the success of this approach will depend on finding some acceptable means for selecting potential nominees. We discuss one possibility, below, when dealing with the potential role of local government.

Finally, we note that the creation of a CAB is really a pre-requisite for the development of an effective customer charter. In this respect, the role of the CAB is that of negotiating with the organisation the terms of the customer charter. We regard this as important as, even if there is a strong commitment within the organisation to the concept of a customer charter, it may still be difficult to identify the issues which it should cover, and the way in which they should be dealt with, in the absence of an informed customer perspective as a sounding board and dialogue partner in the charter's development.

The contribution of the CAB to the organisation will be a function of the brief it has and the resources made available to it. The brief should be explicit that the board has a role in:

- Negotiating/developing the terms of the customer charter;
- Mediating between the organisation and public concerns over resource allocation. Here the objective is to facilitate the customer advisory board becoming an independent validator of the resource allocation decisions which the organisation makes;

- Within purchasers, an advisory role on how the purchase organisation should go about matters such as needs assessment, prioritisation, and specification of the criteria for supply of services;
- Within service providers, an oversight of how the organisation manages service delivery and deals with customers.

In respect of the four objectives, the CAB:

- Helps underpin the processes by which the public gains an assurance that its voice has been heard. In particular, part of the role of the customer advisory board should be an oversight of the consultation processes which the organisation follows, both externally and internally, with a brief to recommend (in a non-binding manner) the steps the organisation should take to improve its performance;
- A key part of the CAB's role, especially within purchaser organisations, is to form a judgement and provide input on how resource allocation is managed (and how decisions are communicated to the public). In this respect, provided the CAB is itself appointed through a process which has legitimacy and attracts people of recognised integrity and independence, it has the potential to be an important validator;
- Oversight by the CAB of consultation processes should help focus the organisation on the need to achieve more than just legal compliance;
- An effective CAB, seen as genuinely representing the public interest, should help lessen the public demand for elected representation. This issue is discussed in more detail below in relation to the suggestion for an elected accountability body in paragraph 7.2.7 below

Related to the concept of customer advisory boards, is the concept of stakeholder consultation. This is not something which requires any structural change; it is simply a matter of good practice and is already, to varying degrees, part of the activity of all RHAs.

Stakeholder consultation is a matter of scanning the environment to identify parties who are likely to have:

- An interest in present or future decisions which the organisation may take, coupled with
- The potential to contribute to or restrict the organisation's ability to carry out its activity.

Stakeholder consultation is accordingly a matter of identifying parties who have this capacity and ranking their capability to impact on the organisation's activities. The organisation should then seek to maintain regular dialogue with those stakeholders intended to:

- Understand and, where possible, accommodate their concerns;
- Raise their level of understanding of what the organisation is seeking to achieve.

In an area such as health, this may include seeking out ways to bring unorganised but potentially influential stakeholders together as a means of facilitating consultation. An obvious and continuing threat to planning within the health sector is public reaction. The "public" as a stakeholder currently takes no formal organised form. The issue for health sector organisations is how to deal with that lack in order to better understand and manage public expectations and ensure better alignment between these and what the health sector is able to deliver.

7.2.5 Statement of Intent

We assume that, as Crown Entities, both the new national funding agency and the Regional Hospital and Community Services organisations will be required to produce a Statement of Intent (SOI).

Section 41D of the Public Finance Act 1989 sets out the requirements for a SOI. In essence, the document is an agreement between the Responsible Minister and the Crown Entity spelling out the objectives of the entity; the nature and scope of the activities it intends to undertake; the performance targets and other measures, including various financial measures, against which to judge its performance; and such other matters as may be agreed between the Responsible Minister and the governing body of the Crown Entity.

The SOI can therefore serve as a quite comprehensive document for governing the operations of the entity and its management of key variables, both internal and external.

For the purposes of this project, Section 41D is sufficiently comprehensive to support provisions in the SOI specifying the approach which the RHA should take to:

- Consultation;
- Risk management, broadly defined.

A review of the CRHA's various SOIs shows that the document has in fact dealt both with consultation and with risk management.

The section of the SOI dealing with consultation has been changed with each successive statement, implying a real awareness of consultation related issues and a fine tuning of requirements in order to reflect experience.

Some of the changes are admittedly difficult to understand. The first two SOIs included as one of the aims of consultation to "facilitate effective decision making". This aim does not appear in the latest SOI.

Generally, the description of consultation is comprehensive and sensitive to the various issues which have been identified in this report. In each of the three SOIs

we have reviewed, there is a strong emphasis on active consultation. Thus, the 1994 statement includes "the authority actively consults with community health groups, providers, special interest groups, territorial local authorities, and national organisations". The latest statement includes "Central RHA actively consults with Maori, Pacific Islands people, people with disabilities, community health groups, providers, special interest groups, territorial local authorities, national organisations and users of health and disability services".

MDL, in a parallel project for the CRHA, has been involved in a number of meetings with Community Health Groups intended to gain their impressions of consultation with the CRHA. Almost without exception, the feedback has been quite strongly critical. Community Health Groups have complained that the CRHA never acknowledges submissions which they make and quite commonly fails to respond to correspondence (we are aware that both of these issues have now been addressed). Our strong impression from these meetings was that few of the CHGs would see their relationship with the CRHA as consistent with "actively consults".

We continue to be of the view that the Statement of Intent is the proper document in which to spell out the Responsible Minister's expectations regarding consultation by the CRHA (and for that matter the obligations which the CRHA will impose on providers where consultation is more properly a provider responsibility). Our experience with Community Health Groups suggests that the SOI should include some performance measures and means for monitoring performance to ensure that the CRHA is achieving what the Responsible Minister expects of it or, if it is not, that there is good reason (we recognise, for example, that consultation is a two way process and there will be circumstances in which consultation breaks down for reasons which are no fault of the CRHA).

One of the matters which SOIs should cover is major risks to the entity's is business or the Crown's interests and the measures proposed to manage those risks. Low public confidence is one such risk. It carries with it the potential for political pressure to spend more money on health, and also undermines the role people can play, if motivated, in achieving desired health outcomes. Accordingly, it represents a potentially significant fiscal and policy risk and as such should be the subject of specific provisions regarding management.

This should see the SOI setting out the means which the organisation intends putting in place to assess the degree of risk and to ensure that it is appropriately managed. This may well include the adoption of one or more of the options discussed in other parts of this section.

In current practice, the risk management section of the SOI has quite a narrow focus, concentrating primarily on demand driven expenditure. In our view, the risk management section should be extended to include the fiscal and policy risk associated with low public confidence. We recognise that this may not be an easy matter to measure. Nonetheless, we consider it important that the CRHA be focused on the relationship between its performance, public confidence, and

political pressure for additional health expenditure. The mere fact that it may be difficult to measure performance should not be seen as an argument against requiring the CRHA to consider how best to manage this risk.

In relation to the four objectives:

- We see the Statement of Intent as an essential element in developing processes which give the public an assurance that their voice has been heard. The statement should specify general principles and anticipate that the CRHA will monitor performance and report its achievements.
- Its role in allowing the public to understand the need for tradeoffs is less direct, but still important. This should be realised through the section dealing with risk management, with an emphasis on what is required to minimise fiscal and policy risk.
- Dealing with the issue that consultation needs to be more than just legal compliance should be an explicit element in the drafting of the consultation section of the SOI.
- The SOI may also play a role in designing the structural arrangements which answer the demand for representation, without compromising the need for governance, by requiring the CRHA, in its contracting arrangements with major providers, to have in place mechanisms which will facilitate public input without the need for an electoral component. This may, for example, lead individual RHAs to encourage Regional Health and Community Service organisations to adopt measures such as a customer charter and a customer advisory board (matters which might also be pointed to in the separate SOIs for those bodies).

7.2.6 Local Government Involvement

We have seen (7.1.11 above) that there has been a trend in recent years for local authorities to accept a role as advocates for health services with a number initiating their own reviews of provision within their local area. We expect this trend to continue as, increasingly, the public looks to local government to intercede on its behalf. Our observation suggests that there is something of an iterative process going on. The more that the public looks to their local authorities to act in an advocacy role, the more local authorities are inclined to do so and, as a consequence, the more the public expects them to undertake this role.

We also note that many local authorities are loud in their complaint that this amounts to further "load shedding" by central government, expecting local government to take up activities which were previously funded by the taxpayer. However, despite this protestation, it is our assessment that local authorities themselves are more and more coming to see this kind of activity as part of their "core business" as they adopt more of a governing role within their district.

In a parallel project for the CRHA, dealing with the future of Community Health Groups, we have prepared a paper looking at possible options which was written to serve as the basis for discussion with local authorities. We shared this paper with the General Manager, Policy, of a major metropolitan local authority outside of the CHRA's area. His response is worth quoting:

> "I would strongly support your 4.4 regarding what the RHAs should consult on. It is frustrating to be consulted on, for example,

> transport policy, but not have an opportunity to input to the RHA's statement of intent and overall purchasing policy.
>
> "With the recently announced changes to abolish the RHAs and replace them with a central purchasing authority, I think the matters canvassed in your paper have taken on a greater importance. From my experience with this local authority I believe that it would be keen to be involved in influencing and shaping national health authority purchasing policies and priorities provided it believed it was being listened to and taken seriously.
>
> "My final comment is that I have observed that provision of health services and treatment facilities is a highly emotive issue and in the end if we are to get sensible decisions and the best value for our expenditure we need a decisionmaking process which is capable of making hard and in the end unpopular decisions. At the moment it seems to me that far too many service provision decisions in this sector serve simply to illustrate the truth of John Rawls' uncertainty principle."

The question is what role local authorities might usefully play. Their emphasis, as illustrated by the quotation above, is on having input into purchasing policy, not just at the micro level, but at the strategic/macro level where decisions are made about the allocation of scarce resources amongst competing ends.

Clearly, it would not be appropriate to pass over decisionmaking responsibility on these matters to local authorities, even if they had the required expertise. The point of a national purchasing policy is to have in place a means of deciding on resource allocations as between different communities and to have the flexibility to do this in response to changing conditions.

Increasingly, local authorities are capable of providing:

- Well researched indepth knowledge of circumstances within their local communities. The past few years have seen a significant qualitative leap in the policy capability of many local authorities.
- A democratic mandate to support the selection of appropriate community representatives to undertake consultation with the RHA and other health sector organisations.

In the Community Health Group project for the CRHA, we have put forward the proposal that CHGs be replaced by bodies part funded by the CRHA and part funded by local authorities, with members selected by the local authority against an agreed set of criteria and through an objective selection process.

In discussion with a number of local authorities, this suggestion has been seen as a useful starting point but a number have responded by saying that the RHA's focus

should be not on structure as such but on the outputs/outcomes that it requires. They have suggested that the RHA should simply set out its criteria for the purchase of advocacy services and invite individual local authorities to contract with it in terms of those criteria. It would then be over to the local authorities themselves to decide what structural arrangements they wished to put in place so long as they were capable of meeting those criteria. We see this as a very positive response as it allows, amongst other things, adaptation to local circumstances - and advocacy issues within a widely dispersed rural authority are significantly different from those within a concentrated urban authority to take just one example.

Criteria could include such things as:

- A good research/policy analysis capability.
- Establishment of an advocacy group (whether it be a council subcommittee, working party, or independent body with membership appointed by the council) specifically tasked to represent health interests, rather than the interests of any special interest group and with membership and experience appropriate to the task.
- A preparedness to work co-operatively at a regional level in order to support discussion on strategic/macro level matters as a basis for developing understanding of trade-offs (local authorities are accustomed to doing this under the umbrella of Local Government New Zealand).

In some respects, what we are proposing could be seen as duplicating the customer advisory board option. We would certainly not see this as being the case at the level of the Regional Hospital and Community Service organisation because of the different nature of provider and purchaser. However, we do believe that there is a risk of overlap between this proposal and the idea of a customer advisory board for the new funding agency or its regional offices.

We believe this risk should be managed by clear specification and understanding of the roles of the two separate options. The primary role of the customer advisory board is to act as an overseer of process within the RHA as a means of ensuring alignment between internal and external processes and reinforcing the legitimacy of the RHA's decision making. The primary role of local authorities should be seen as facilitating advocacy services on behalf of their local communities, including facilitating the process of understanding tradeoffs as between different communities within the area of an RHA (or regional office of the national funding agency).

Earlier, we commented on the process for nominating members of customer advisory boards for Regional Health and Community Services organisations if these were adopted. Given the interest which local authorities are now taking in health and disability services issues, and their own democratic mandate, we see merit in them playing a significant role in nominating, or at least managing the nomination process, for the members of those customer advisory boards. It may well be that

Local Government New Zealand, through its various zones, would be prepared to play a role in co-ordinating such a nomination process.

Local authorities have growing experience with the management of reasonably well structured and objective nomination/selection processes. It is now quite common for them, in selecting directors for local authority trading enterprises, or trustees for the many and quite substantial trusts within the local government sector, to go through a process under which:

- A job description/person requirement is developed;
- Nominations are sought from the public;
- A shortlist of prospective nominees is prepared by someone independent of councillors (sometimes an external consultant, sometimes someone within council management);
- Shortlist candidates are interviewed and an appointment made.

There is another reason for involving local government in this way. It is clear that the sector's commitment to involvement in health advocacy is irreversible. Local government's level of involvement is likely to increase. Public support for this role appears quite strong. Accordingly, taking a proactive approach to developing a means for local government involvement can be seen as a sensible strategy for managing the environment within which health and disability services operate.

We see this approach as offering considerable promise in managing consultation with different communities of interest, especially where those differences have a substantial geographical component as in, for example, rural/urban, Maori (who as Tangata Whenua, are very much people of a specific geographic location) and communities with different socio-economic characteristics. At the moment, there is little or no filter between the CRHA and individual communities and no process, external to the CRHA, for co-ordinating, analysing and expressing the concerns of those communities. We see local authority involvement in establishing appropriate means of representing the interests of those communities as a major step forward in creating a managed consultation process which has both democratic legitimacy and the competence needed to deal with complex issues.

Our assessment of this option is made on the assumption that the terms of the agreement between the CRHA and individual local authorities reflects the principles outlined in this part of the paper.

We assess this option against the four objectives as follows:

- Local authority involvement should certainly be able to give the public an assurance that their voice has been heard at the point of decision making, as the local authority should be seen as a respected independent guarantee of this;
- Local authorities themselves currently operate under conditions of fiscal constraint and invest increasing effort in educating their communities on the need for tradeoffs (see the discussion of Wellington City Council's current draft Annual Plan in 7.1.11 above). Accordingly, we would expect local authorities, or advocacy structures supported by local authorities, to be well placed to recognise similar needs in the health sector and assist their communities understand this need. We also consider that creating a body which has an advocacy function across the whole of the health sector rather than on behalf of a particular special interest should encourage this development (we note that Community Health Groups, as an example, have not been able to carry out this function as they have been focused, primarily, on consultation in respect of individual service proposals);
- Local authorities themselves well understand the problem that consultation in the legal compliance sense is insufficient and could be expected to ensure that any advocacy structures which they supported dealt with this issue;
- Local authorities themselves have a democratic mandate. Accordingly, advocacy structures which have their backing should serve as at least a partial response to the demand for an elected voice in the health system. Taken together with customer advisory boards, a strong case could be made that the concern underlying the demand for elected representation had been properly met and at a level of competence unlikely to be matched by elections to a special purpose body.

7.2.7 Elected Boards

We are uncertain as to the exact intent of the commitment in the Coalition Agreement that "elected community representation will be considered by a joint working party of coalition MPs as to the most appropriate place for public representation in the health sector". However, it seems a reasonable inference that this commitment was included because politicians believed that a significant portion of their electorate wished to see a return to some form of elected involvement.

This public concern, to the extent that it exists, is clearly not the result of reasoned analysis of difficulties within the present system. Rather it seems to reflect a nostalgia for "the way things were" and a belief that elected representation was a key element in what many obviously believe was a better and fairer system.

We have strong reservations regarding the reintroduction of an elected element into boards which have a governance responsibility. In our view, there is a clear conflict between the requirements for effective governance and the mandate which an electoral process will produce. The former is concerned with matters such as:

- Effective and efficient management of resources.
- Maintaining the integrity of existing constraints and funding powers.
- Accountability to the taxpayer as funder.

Elected members will instead see themselves as accountable to their constituents. Given that those constituents are not the funders, that accountability will be in terms of:

- Effectiveness in increasing resources.
- Ability to meet the felt needs of the specific interest groups responsible for electing them.

This statement of the way in which elected members are likely to see themselves can be seen as a perversion of a more legitimate role: that of holding the organisation accountable for its effectiveness in delivering services for the constituency which the elected members represent. This argument separates accountability back to the Minister as agent for the taxpayer as funder, from accountability to the constituency served by the health services organisation concerned, to the public whom it serves. This line of argument can and has been developed to say that ministerial accountability is not sufficient by itself. In other words, the Minister as agent for the public (service recipients) as principal can not be sufficiently informed to discharge his or her responsibility. There is also an argument that the Minister has an inherent conflict of interest in that he or she is both agent on behalf of the taxpayer, concerned to minimise expenditure, and agent for the public, concerned to maximise service.

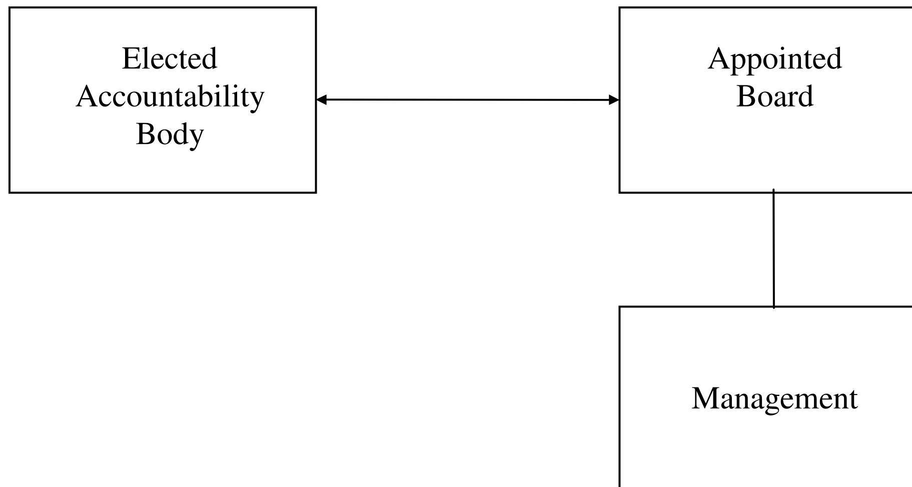
Accordingly, in responding to the issue of an elected input, we would suggest looking at two separate courses of action.

The first is to look at the process by which people become members of the governance boards of health sector organisations. Associated with public concerns over the quality of the health system are concerns that the process of appointing board members is overly dominated by political considerations. This appears to be reflected in the Coalition Agreement commitment that:

> Political appointments whether by way of review or new appointments shall be made with the joint consent of the coalition parties or party leaders pending the establishment of an independent body.
>
> This provision appears to foreshadow a concern, on the part of the coalition, to move away from a political appointment process to a more objective process outside the immediate control of ministers.

As one measure to improve public confidence, we would recommend adopting a formal and open process for selection following largely the process outlined above which the better local authorities now use; this would seem to be consistent with the statement in the Coalition Agreement. It should at least remove concern that boards are there simply to do the Government's bidding.

The second possibility we would suggest, if there is felt to be a need to introduce an elected component, is to put in place a separate component to carry out an accountability role on behalf of the public. The relationship would look something like this:



The mandate of the elected body would not be to act in a governing role. Instead, it would be to represent the interests of the public in negotiation with the board of the health services organisation. It would need to have its own separate resource base and be integrated into the various accountability mechanisms which now apply. For example, it might be given a formal role in reporting on:

- The statement of intent.
- The statement of service performance.
- The statement of shareholder expectations or whatever other document may apply to represent the owner's interests.

We would see this approach as something of a compromise designed to recognise the public concern for an elected input but structured to avoid conflicts at the governance level.

Our preference would be to use other mechanisms such as the proposed customer advisory board and various mechanisms for utilising input from and through local authorities.

However, we would see some merit in this approach to providing elected representation provided it was properly managed and if the political judgement was that re-introduction of an elected component, within bodies such as Regional Health and Community Service organisations, was essential in order to manage public pressure on the health system. It would require health services organisations to accept the legitimacy of the role of the elected body and be prepared to work with it. Over time, hopefully, this would provide a means of improving understanding, as

between that body on the one hand and the health services organisation on the other, of the expectations each had and of the limits which naturally exist.

It may also provide an opportunity, although this could be seen as somewhat wishful thinking, to assist educate the public on the nature of the genuine limits which exist within the health system.

In respect of the four objectives, our assessment of this option is:

- It should only be introduced if the political judgement was that an element of direct elected involvement was essential to restore public confidence that their voice was being heard in the health system;
- We have reservations that such a body would be effective in assisting the public understand the need for tradeoffs. We believe that there is a risk that the members of such a body would see, as one of their roles, advocating for more resources, if only because of a concern to be re-elected.;
- We do consider that such a body would help ensure that consultation was seen as more than just a matter of legal compliance, especially if it had a role in matters such as advising on the Statement of Intent;
- We see this as less satisfactory than any of the other options for answering the demand for representation without compromising the need for governance. There is a risk that a body of this kind could be seen, especially by non-government political interests, as falling far short of what was required, thus leading to argument that election was indeed necessary, but it had to be an elected board.

Our foregoing assessment needs to be tempered by one further issue, this is the extent to which such an elected accountability board was resourced. To be effective in carrying out an accountability role, such a board would need a reasonably high-powered secretariat. Taken across the health sector as a whole, this could be seen as a very expensive means of dealing with an issue which could be better resolved in other ways, such as the combined CAB/customer charter/local authority advocacy services proposals, which become an integral part of how the health funding system itself functions, permeating culture and operations at all levels.

A TRUST/CIVIL SOCIETY PERSPECTIVE

In Section 6.3, we provided an overview of current thinking on social capital, civil society and the issue of trust.

There are essentially three lines of argument being brought together. They are:

- Debate on the relationship between social capital, civil society and the strength of democracy being developed through an analysis of the relationship between various forms of civic engagement and changes in the quality of public life;
- Analysis, from a legal perspective, of the changing basis of the individual's relationship to society, which identifies a shift from a perspective which emphasises both duties and rights to one which sees humans as little more than autonomous, rights bearing individuals;

- Fukuyama's emphasis on trust and its relationship to transaction costs, seeing the absence of trust as being effectively a tax on society through higher transaction costs.

These three lines of enquiry are coming together in a broad based debate on the relationship between social capital, civil society and good government, with a strong concern to draw out implications for policy makers and politicians. This part of the debate is still very much in its early stages. In part, this is because of the difficulty of establishing causality. We have seen Putnam's argument that the decline in civic engagement is undermining the quality of civil society and in turn affecting democratic participation and respect for government. Other participants in the debate argue that the causality may run the other way. For example, that the shift by political parties from relying on mass mobilisation as a means of building support to the use of television advertising as the primary means of getting out the vote, may itself be a key contributor to decline in respect for political institutions by, in effect, expelling the voters from a process of involvement.

For the purposes of this report, the question is what are the public policy implications. Specifically, does this debate raise issues which should be taken into account in structuring and managing the relationship between the CRHA and the communities it serves?

Some sense of the nature of the American debate can be gained from two articles published in The American Prospect, No. 25 (March-April 1996), the first by Theda Skocpol "Unravelling from Above" and the second a reply by Robert Putnam "Robert Putnam Responds".

Skocpol argues that:

> *"Tocqueville romanticists are wrong to assume that spontaneous social association is primary while government and politics are derivative. On the contrary, US civic associations were encouraged by the American Revolution, the Civil War, the New Deal and World Wars I and II; and until recently they were fostered by the institutional patterns of US federalism, legislatures, competitive elections, and locally rooted political parties"* and
>
> *"Organised civil society in the United States has never flourished apart from active government and inclusive democratic politics. Civil vitality has also depended on vibrant ties across classes and localities. If we want to repair civil society, we must first and foremost revitalise political democracy. The sway of money in politics will have to be curtailed and privileged Americans will have to join their fellow citizens in broad civic endeavours".*

Putnam's answer is to argue that what is needed is a thorough, empirically grounded debate about how to revitalise civic engagements. He says:

"Public policy will be part of the answer, as I wrote three years ago. Take a single contemporary example: neighbourhood crimewatch groups seem to be a notable exception to the general decline in social connectiveness over the last quarter century, and most such groups emerged from community crime prevention programmes sponsored by various federal, state, and local agencies, beginning in the 1970s, working often in partnership with community groups. So Skocpol is right to criticise "Tocqueville romanticists" who would claim that politics and government are irrelevant (or worse yet, intrinsically inimical) to civic vitality and to idealise "bottom up" solutions …" and

"On the other hand "top down" or government-driven solutions are hardly a panacea, and I cannot believe that Skocpol holds that extreme view, either, despite language in her commentary here that occasionally suggests that an active civic life can exist only as the product of an active government. The Washington Elite, whose creativity she celebrates, may have played an important role in creating the American Legion, the Farm Bureau Federation and the PTA, but so also did millions of ordinary Americans in thousands of local communities. Finding practical ways to encourage and enable their descendants (us) to reconnect with our communities, especially across lines of race and class, is a matter of high urgency, and we should not be distracted by false "either/or" debates."

We have quoted this exchange both to endorse the view that public policy is a necessary part of the answer, and because of Putnam's emphasis on neighbourhood crimewatch groups. He cites these as an almost unique example in modern America of a government initiative which has specifically recognised the contribution which the strength of community interaction can provide to dealing with a public policy issue.

There is an obvious parallel in New Zealand, with Safer Community Councils and the initiatives which they have supported, including neighbourhood watch groups. As the Crime Prevention Unit's guide to setting up a Safer Community Council outlines, the Safer Community Councils are a partnership between government and community through territorial local authorities. "The Government's contribution is to assist communities by providing advice, information and funding, while the community's contribution is to organise a Safer Community Council which will then co-ordinate resources and programmes available from the Government and the community".

The work of this programme was endorsed by the Prime Minister, the Rt Hon J B Bolger, in an address to the Safer Communities Council meeting on 4 April 1997. He not only endorsed their roles as "a unique partnership between the Government

and the community", but confirmed the Coalition Government's full support and went on (in a possibly delphic manner) to comment that "while there is little more I can say in advance of the Budget, I know it has been developed with many of the concerns of Safer Community Councils kept firmly in mind".

This is the one New Zealand model of a central government initiative which, in terms of the social capital/civil society debate, is quite specifically targeted on the contribution which strong civil society can make to dealing with a critical public policy issue. The involvement of territorial local authorities as Government's partner is a recognition of the leadership role which local authorities play in their community and the local knowledge and networks which are available to territorial local authorities, but typically not to central government or its agencies.

The broad proposition we would advance is not only that specific government initiatives can strengthen social capital and civil society, but that:

- Intelligent harnessing of the strength of civil society can support government initiatives;
- Government initiatives, operating in the civic arena, but without regard to social capital/civil society issues, can undermine civil society and the commitment to government objectives. This too is part of the theme of the current American debate.

To a degree, this analysis is still quite speculative. However, we would suggest that there is sufficient force in the arguments to encourage policy makers to take into account the potential impact on civic engagement, and the contribution which strong civil society may be able to make, in the development of structural and organisational arrangements. Specifically, we would argue that the emerging evidence places emphasis on finding ways in which the public can be engaged in health services planning and delivery.

8.0 CONCLUSION

8.1 This report has sought to provide a broad overview of public involvement in service planning and delivery within the New Zealand health system, as seen through the experience of the Central Regional Health Authority. It has supplemented that overview by:

- A brief account of changes in the New Zealand health system since the early 1980s, focusing on the impact which those changes, and ministerial/governmental descriptions of them, may have had on public expectations regarding the relationship between purchasers, providers and the publics they serve.
- A look at a broadly parallel New Zealand process, consultation by territorial local authorities.
- A review of overseas experience with a particular focus on well known initiatives such as the Citizens' Charter.

8.2 The report has recognised that we are looking at a system which is still very much in a state of evolution. The CRHA has been on a considerable learning curve in public consultation. It has had to undertake this learning at the same time as getting to grips with managing a very large number of provider contracts.

8.3 The case for public involvement has been considered from three separate perspectives:

- The *operational level* - the needs of managers within New Zealand's health system for public input/involvement as a means of enabling better decisions.
- What we have termed the *strategic level* - looking at the civil/political context within which governments pursue social objectives. We have drawn on the emerging debate on the role of social capital and civil society in enabling good government, including related arguments regarding the role of trust and the effect of the shift in recent years towards a rights based relationship between individuals and the societies in which they live.
- As a factor in managing fiscal and policy risk.

8.4 Recognising that the social capital/civil society debate is still far from settled, we have nonetheless stressed that governments, in considering the initiatives which they undertake, should have regard to the potential impact on social capital and civil society. We have used the specific illustration of Safer Community Councils as an example of an initiative which appears to have drawn, very effectively, on local social capital as a means of achieving desired ends.

We have reviewed a wide range of different means of enabling public involvement. Some of these have been very specific in the sense that they focus on a particular issue or issues; others have more of a structural characteristic in the sense that they focus on creating the organisational conditions for effective public involvement.

8.5 In the final substantive part of the paper we have canvassed five selected options which we recommend should be pursued. All of these are structural in nature. In effect, we have taken the view that the circumstances in which the New Zealand health system now finds itself needs a structural/organisational approach to facilitating public involvement and that, if this can be achieved, then the question of which means of consultation/involvement to use on which occasion will prove comparatively simple to resolve. On the other hand, if the structural issues are not addressed, then we believe that no specific means for consultation/involvement, regardless of how theoretically ideal it may be, will be effective to build and maintain the public confidence which is a precondition to an effective, efficient and legitimate health system.

8.6 We conclude that the combination of a customer charter, a customer advisory board, and a partnership with local government in facilitating community based advocacy offers the best prospect for a structure for public involvement which will be effective both to rebuild public confidence and provide the means of gaining public understanding of the constraints under which a health system must necessarily operate. We see this as underpinned by appropriate provisions in the relevant statements of intent.

8.7 Finally, although we have canvassed the possibility of an elected component within either Regional Health and Community Services or within the proposed national funding agency or its regional offices, we are not enthusiastic about this. Direct election to the governing body (whether to produce a minority or a majority elected membership) we see as contributing neither to genuine public involvement nor to the maintenance of fiscal discipline. The alternative we suggest, of an elected accountability board, we see as a potentially acceptable compromise if the introduction of an elected component is seen as unavoidable. However, we see the potential risk with this option that it could be seen, especially by non-government political interests, as second best to a fully or partly elected board thus risking an outcome which we would not support.