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Challenges for District Health Boards as needs assessors

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District Health Boards (DHBs), created by the New Zealand Public Health and Disability Act 2000, are required for the first time to assess regularly, and meet from their budgets, the health and disability service needs of local populations.[1] A new direction has been set in defining and responding to the health needs of those who do, and do not, access the New Zealand health system.[2,3] According to Coster,[4] this requirement for health needs assessment will involve 'assessment of the population's capacity to benefit from health care services, prioritised according to effectiveness, including cost-effectiveness, and funded from within available resources'. The Ministry of Health has provided an overview and guide for DHBs on how to undertake health needs assessments of their populations.[5] DHBs were required to deliver their first set of comprehensive health needs assessment documents to the Ministry of Health by 1 November 2001.

It is intended that health needs assessments will provide DHBs, at least three-yearly, with information on health need in districts,[5] which can inform overall population-based priorities for services, strategic planning processes and annual plans. DHBs face challenges as they endeavour to meet requirements for health needs assessments, community consultation and prioritisation. Only by recognising the possibility of mishap, and setting reasonable expectations, will DHBs and management be able to agree on a sensible course forwards to meet Ministry requirements. This paper seeks to warn DHBs of challenges facing them as they contemplate three yearly needs assessment processes. Six challenges are discussed.

1. Different concepts of 'need'

Definitions of 'need' have been much debated.[4,6-10] Need for publicly financed health services is often defined by economists as 'capacity to benefit'.[10] However, there are many other attempts to conceptualise 'need' for services and with contending definitions of need in play, DHBs will have to thread their way between them.

The question is: how will DHBs understand and interpret the need for health services? In our opinion, that ability will require acceptance by Boards that need can, in principle, exist regardless of a known effective treatment or resource to provide the appropriate treatment.[9] For example, if a woman has breast cancer, her need for care does not depend on decisions to purchase or offer care, or even on whether effective care is currently possible. DHBs embracing a definition of need must further determine rights to services (including their requirement to consult Maori), elicit populations wants, and obtain 'expert' agreement on when and how people should be able to access effective services.[9] But which expertise will Boards value highly? And, in reality, how rigorously will their responses to the foregoing issues be developed and applied, given the practical realities of service planning? Clarification of existing service contracts presents a significant challenge, let alone embarking on a higher

level of activity regarding future service need. It will be useful for DHBs to clarify their definition of need.

A distinction is commonly made between personal health and population health.[11] This distinction lacks relevance to traditional Maori and many Pacific peoples who do not distinguish between their individuality and group identification. Instead they respond to perceived needs of family, the tribe or village, and the nation, which are partly defined by the individuals within those groups. For DHBs, this concept of 'self' requires increased emphasis on the health of the whānau and other collectives. DHBs must also demonstrate heightened respect for the spiritual dimension of health. The difficulty is that although meeting 'health need' as distinct from 'health services need' is an intersectoral responsibility, DHBs are not funded to provide services intersectorally. DHBs will have to cope with a range of different and legitimate concepts of 'health need'.

2. Clarity of objectives

Few would contest the concept of health needs assessments informing equitable provision of health care. A clear description of the objectives of such assessments is needed to facilitate a practical understanding of how to undertake and support health needs assessments. Part of that understanding relates to the linkages between assessments, prioritisation, and integration into planning and purchasing of local health services to produce effective change.[12] Further clarity regarding the objectives for the process may come from the answers to these questions:

- Will health needs assessments make any difference to the way that DHBs prioritise and purchase health services?
- How will DHBs manage raised public expectations that will almost certainly follow a process of public consultation?
- How can DHBs faced with financial deficits prioritise new services?

The first is an important question and the subject of research currently at an early stage. The second indicates that DHBs will need to be careful in managing public expectations, for example through public education. Regarding the last question, DHBs will have difficulties with prioritisation, given the resource-constrained environment and current deficits. Prioritisation will be difficult for DHBs without new health funding. Boards will be reluctant to disinvest from existing services to invest in new priorities for health service delivery. They will need support from the Ministry and Minister of Health to do so. Removing funding from existing services is always difficult, and the allocation of new funding remains uncertain. Mechanisms such as ringfencing also constrain shifts within the DHB budgets. DHBs will have some tough choices to make, and these will not lessen with the passage of time.

3. Resources

Key competencies for health needs assessments include public health and epidemiological knowledge; statistical skills; knowledge of qualitative methods; skills in economic evaluation; consultation skills; local knowledge; and respect for cultural diversity. Since this knowledge was not previously held within Hospital and Health Services, existing competencies have had to be supplemented by recruiting new or

contracted staff. By banding together, regionally or otherwise, DHBs are thus building capacity. Three DHBs in the Auckland region formed a needs assessment and prioritisation regional workstream to manage the process. In conjunction with existing capacity within DHBs, the group is progressing needs assessment and prioritisation in a coordinated manner, minimising the cost of the process. Even so, time and resource pressures are considerable.

The ability of Boards to respond to demonstrated need will be greatly constrained by their financial position. Indeed, DHBs are already experiencing difficulties. Disputes over pay rates to radiation therapists, nurses and mental health workers in DHBs such as Canterbury, Waikato and Auckland are recent examples.

A tight funding environment means that DHBs will need to consider disinvestment in a number of areas. How will that be done without causing harm? Prioritisation of new monies is an easier challenge than disinvestment with its implications for staff, services and communities. Open dialogue will be necessary to resolve the difficult challenges of prioritisation in a climate of limited resource.

4. Timeframes

Timeframes have been tight with DHBs under pressure to meet the November 2001 deadline for forwarding the first round of health needs assessments to the Ministry of Health. A number of DHBs delivered late. Some twelve, mainly smaller DHBs, grouped together and commissioned the Wellington Clinical School to conduct needs assessments on their behalf. Meanwhile, Counties-Manukau DHB was able to publish the epidemiological data necessary for their needs assessment because they commenced the project one year before the November deadline.[13] These recent experiences of Boards indicate that adequate time must be provided for DHBs to undertake future health needs assessments, including the collection of community data. Even then, epidemiological data collected on presentation/intervention (treatment) outcomes are skewed by historical artefacts (financial constraints, waiting list juggling, service availability) and therefore do not represent the community's real needs for outcome.

5. Consultation

In shifting from the purchaser-provider split introduced in 1991 toward a more centralised health sector, New Zealand has now sought to strengthen its embrace with public consultation. Community input to health needs assessment and the prioritisation of health services have been perceived as a way of enabling and encouraging individuals and groups to express, through voluntary, democratic participation, their wants (felt needs) and perspectives on issues that have yet to be decided. Health needs assessments must be done *with*, rather than *to*, local communities[5] that are the repositories of data that will inform health needs assessments.

Other reasons for consulting the public include the importance of partnership and collaboration between funders, providers and the community, alongside equity and fairness, accountability, acceptability, and acknowledging and reflecting multicultural values.[2] For such reasons, the Ministry of Health expects consultation with communities to be an important function of DHBs from an early stage and there are

general[14] and legal[1,15] mandates for consultation with both the general public and current service users on needs and priorities.

The presence of elected representatives on Boards is one key part of community involvement, but DHBs are encouraged to be as transparent as possible in decisionmaking, and where appropriate, to include the community in decisions. Specifically, Boards must avoid both the public belief that a final decision has already been made (overpreparation), as well as underpreparation in the forms of poorly developed proposals, ineffective methods of dissemination, and failure to involve appropriate public groups at different stages of the consultation.

Consultation on Strategic Plans is occurring presently with public meetings being held within Districts to explain these plans to the public and obtain its views. Considerable variation in scope of consultation is already apparent, varying from five advertised meetings to over fifteen in some DHBs. How will DHBs be able to respond meaningfully to public submissions, given finite existing budgets? Presumably, to manage expectations, DHBs will initially have to frame the consultation and options for change.

6. Prioritisation

Prioritisation is described within guiding documents, such as the New Zealand Health Strategy,[2] The New Zealand Primary Health Care Strategy,[3] The New Zealand Disability Strategy,[16] and other strategies for Maori and Pacific peoples. Thirteen priority population health objectives have been chosen for immediate action[2] and will focus the thinking of DHBs in strategic planning. However, the strategy documents give little or no guidance on the relative importance of goals and objectives. DHBs are required to 'have the capability to prioritise services to meet the needs of communities, within the constraints of their service funding and the direction of the New Zealand Health Strategy and the New Zealand Disability Strategy'.[2,16,17] Health needs assessments are a key input into the process for prioritisation of services, influencing how services are purchased, or not, for a community. Implicit in prioritisation is the concept of rationing, which implies the distribution of health services according to available resource. Rationing decisions may be determined at system level in Vote Health or at service level by DHBs. But will they rework the previous Health Funding Authority prioritisation process, or simply adopt it? Will DHBs incorporate the findings of health needs assessment exercises into their prioritisation exercises, or will the two be separated? And how will the needs of low socio-economic groups influence the health agenda? It will also be interesting to see how well local purchasing requirements can be met in the context of a fairly substantial national priority agenda.

Summary

DHBs face the foregoing challenges in the current and future environment, as they take on democratic representation for the population, particularly in health needs assessment, consultation, prioritisation and health service purchasing. Need and objectives must be clearly defined at an early stage in the context of resource constraints and timeframes that will challenge the ability of Boards to conduct needs assessments. Consultation with the community and other, expert groups must inform needs assessments. But it is not clear how the prioritisation process will work,

particularly regarding the ability of local agendas for purchasing of health services that complement the national agenda. Recent health crises have shown that DHBs, without Government support, cannot easily meet such challenges in the new decentralised environment. Consideration must therefore be given to how these identified challenges for DHBs as needs assessors can best be met.

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