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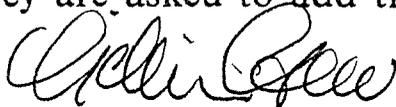
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COMMUNITY PARTICIPATION IN POLICY DEVELOPMENT: A CASE STUDY
OF THE NATIONAL CERVICAL SCREENING PROGRAMME

A thesis presented in partial fulfilment of the
requirements for the degree of Master of Educational
Administration at Massey University

Gillian Dorothy Anne Grew

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Abstract

This thesis is a case study of the development of the National Cervical Screening Programme policy. The aim of the study was to identify and describe the political, social and ideological factors which may have influenced the National Cervical Screening Programme policy. The policy-makers included community or consumer participants as well as professionals. This relatively unique feature of community involvement was also a focus of study. The study involved a literature search and review as well as interviews with key informants. Cervical screening on a population basis was trialled as far back as the 1960s at the same time that Professor Green was questioning the efficacy of early treatment of cervical abnormalities. Green's controversial research resulted in a Royal Commission of Inquiry which recommended the establishment of a population based national cervical screening programme.

The political, social and ideological context in which the National Cervical Screening programme policy was developed is described and interpreted. It is concluded that the National Cervical Screening Programme policy was adopted by the Government as a means to ameliorate the crisis of legitimation which was evident during the 1980s. It is further concluded that community or consumer participation in policy development is a highly complex issue requiring further study. Consumer representation is particularly problematic as consumer policy-makers require considerable skills, the acquisition of which may cause them to become less representative of the public whose voice they are intended to be.

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INTRODUCTION

This thesis focuses on consumer participation in the development of a social policy, the National Cervical Screening Programme (NCSP), within the health sector. The thesis is a case study of the NCSP from its genesis in 1988 to the production of a comprehensive Policy Statement in August 1990. The NCSP health policy is significant for a number of reasons:

- It is the first national health programme for all New Zealand women;
- It focuses on prevention rather than treatment;
- It was established on the recommendation of a Royal Commission of Inquiry;
- It is a programme with a high media profile and
- It included significant consumer participation in the policy-making process.

The researcher is the National Co-ordinator of the NCSP and was appointed to this position in June 1990 to implement the NCSP policy. Such close involvement with the NCSP policy necessarily brings a personal perspective to this case study.

The research involved a literature search, including documents held within the Department of Health, and interviews conducted with key informants who were closely involved with the development of the NCSP policy.

As all interviewees would be potentially identifiable, confidentiality was a sensitive issue in this research. Interviewees were informed that their identities would be protected as far as possible and no data would be directly

attributable to specified individuals. For this reason, the members of the policy-making group, the Expert Group, were divided into two sub-groups: the "professionals" and the "consumers". The Department of Health officials and the politician who were interviewed were identified as a third group: the "bureaucrats-politician".

The NCSP policy is a social policy which comes under the umbrella of public policy. Public policy which includes social policy as a sub-set is defined as "the actions and positions taken by the *state* as the overriding authoritative collective entity in society." (Hill & Bramley 1986:2). Social policy is commonly described as catering to the collective needs of society by means of redistribution. Thus, policies dealing with pensions, benefits, employment, housing, health services and education are often included in the social policy category (Hill & Bramley 1986).

Policies are decisions taken by specific, powerful individuals about certain goals and the means to achieve these within a unique context (Jenkins 1978). Traditionally, policy-making individuals have been government officials or bureaucrats, professionals and powerful interest groups (Hill & Bramley 1986). A significant aspect of any unique context in the policy-making situation is the political one. The political climate of the early 1980s in New Zealand, the time leading up to the development of the NCSP policy, facilitated the inclusion of non-traditional policy-makers in the development of social policies (Oliver 1989). Governments were espousing more community consultation and espousing corporatism, particularly in the area of industrial relations. Shirley, Easton, Briar and Chatterjee (1990) have described corporatism as

...essentially a pragmatic approach to the integrative problems of the market economy and it represented a formula for linking the organised economic interests of society with the structures and processes of

decision-making within the modern state. The owners of capital, as well as producers in their organised capacities (i.e. employers and workers' associations) were recognised as major partners in the national enterprise of production and distribution, with each party expected to assume responsibility for making the system work. This meant, in effect, that employers acknowledged full employment as a primary social and economic objective, while workers accepted the need for wage moderation and higher productivity as a prerequisite for economic growth and social well-being. (pg 18-19).

At the same time, a more educated and informed society was demanding an active role in policy-making (Richardson 1983). The climate, therefore, was conducive to the inclusion of community or consumer participants in the development of the NCSP policy. Aspects of the process of consumer participation in the development of the NCSP policy are of particular interest in this case study.

The thesis is comprised of ten chapters. Chapter One describes the relevant concepts in relation to the established literature. It introduces the reader to the notion of policy analysis, defines policy and describes some of the types of policy that theorists have identified. The approaches which have been utilised in the analysis of policy are briefly discussed with an introduction to the approach used in this present case study of policy development.

Social policies have to be viewed as integral to the welfare state and the economy of a nation. Because resources are finite, value judgements have to be made by those in power about the policies which will be funded and given priority. Policy priorities are the consequence of a variety of influencing factors and these are discussed together with the ideology which underpins the different perspectives.

New Zealand has a welfare state which many describe as originating with the enacting of the Social Security Act in

1938. A brief description is given of the growth of the Health Sector in New Zealand which began prior to the Social Security Act of 1938. The Health Sector is firmly based on the medical model which largely assumes that disease can be fully accounted for by deviations from the norm of measurable biological variables (Ahmed & Kolker 1979). Thus, morbidity and mortality statistics become the yardstick by which successful medical intervention is measured. If morbidity and mortality figures are high, for a particular disease, it is deemed to be a significant medical problem. The aim, then, is to reduce the morbidity and mortality figures.

Policy-making has traditionally been the role of bureaucrats and professionals. Consumers, however, have, over the last decade, been clamouring to be involved in policy development (Richardson 1983). The participation of consumers in policy development is still relatively unique and is advocated or opposed by different groups for a variety of reasons. These are discussed in the context of the current social situation in the Western Nations, with particular reference to New Zealand and the NCSP policy.

Chapter Two traces the establishment of the National Cervical Screening Programme. Cervical screening trials were conducted by the medical profession as early as the 1960s. While health professionals had attempted to generate political interest in a national cervical screening programme in the mid 1980s, it was not until Judge Cartwright recommended it in 1988 that the establishment of the NCSP became a policy priority for the Government. Judge Cartwright's recommendation was made as a result of events surrounding controversial experimental research at National Women's Hospital in Auckland and was accepted by the Government in 1988. The subsequent development of the NCSP policy by the Department of Health was fraught with problems which resulted in political intervention. An historical record of the events from the

Cartwright Inquiry to the production of a policy document are presented.

Chapter Three discusses the research methodology used. The case study method including a literature search and interviews with key informants was used. The framework used to guide the research was an adaptation of Leichter's (1979) framework. Leichter developed a framework for the evaluation of policies which combined situational, structural, cultural and environmental factors. For the present research, the addition to Leichter's framework of "more personal factors" enabled the personal perspectives of key informants in the policy-making process to be investigated. The research methods employed are discussed in relation to the problems encountered and the solutions utilised.

In Chapter Four the research data is discussed in relation to the literature on situational factors. Situational factors are impermanent, transient events which impact on policy development. Situational factors include other social policies, significant individuals and groups or organisations which influence the development of policy. The unique situational factors which influenced the development of the NCSP policy are described.

Chapter Five details the structural factors which influenced the development of the NCSP policy. Structural factors are more permanent, or at least relatively slow changing, aspects of society and the political system. The role of the state is a structural factor which is described in relation to the development of the NCSP policy. New Zealand's economic base and the influence of economic policies on the development of the NCSP policy are discussed in relation to the political system.

The cultural and ideological factors which affected the development of the NCSP policy are described in Chapter

Six. The cultural factors include the values which are held by society as a whole. Ideology refers to the ideas which reflect the beliefs and interests of society and the political system.

Chapter Seven relates the significant environmental factors which influenced the development of the NCSP policy. Environmental factors are those structures and values which are located outside a political system yet still impact on the policy-making process. The international policies and events which affected the development of the NCSP policy are described. The role of the media is an environmental factor which influenced the development of the NCSP policy.

The more personal factors of key informants or interviewees who were closely involved with the development of the NCSP policy are described in Chapter Eight. Policy-makers had their own personal aims and provided their personal opinions on many aspects of the NCSP policy. The personal insights and opinions of the interviewees provided an illumination of the process of the NCSP policy development. The personal perspectives of consumer participants in policy-making are discussed in relation to those of professionals and bureaucrats-politician.

The issues associated with consumer participation in policy-making are discussed in Chapter Nine. The consumer representatives described how they performed their role of representation. The difficulties of obtaining true consumer representation and the policy-making skills required by consumer participants were identified as significant issues. There are many reasons given for including consumers in the development of social policies. These are discussed in relation to the development of the NCSP policy.

The conclusions to be drawn from this case study in the development of the NCSP policy which included significant

consumer participation are described in Chapter Ten. Areas for further research in policy development and consumer participation are suggested.

CHAPTER ONE

POLICY ISSUES: A REVIEW OF THE LITERATURE

1.1 Introduction

This chapter begins by presenting some definitions of both public and social policy and goes on to describe policy analysis, the study of policies. Policy analysis serves two distinct functions; the acquisition of the requisite knowledge or information on which to base policy development and the evaluation of existing policies. Policy analysis can be understood in terms of the theoretical approaches used. Two influential, although markedly different theoretical approaches are the pluralist approach and the Marxist approach. These approaches are discussed together with some policy analysis frameworks which have been utilised in the past.

The discussion then moves on to the development of social policies in democratic societies. Following this is a description of the types of policies and how they have been categorised. The links between social policies and economic development are then discussed, followed by a description of Treasury's account of New Zealand's health expenditure. Treasury's recommendations to Government for decreasing public expenditure are then described followed by a critique of the philosophy underpinning Treasury's views.

A brief account is then given of the development of the welfare state in New Zealand. One stated outcome of the growth of the welfare state is the burgeoning of bureaucracies which oversee the development and administration of social policies. The role of bureaucrats in the development of policies is described followed by a

discussion about a policy-making role for consumers. Professional bureaucrats with a scientific perspective have been the developers of health policies in New Zealand and they have influenced the basis on which health care has been established. The chapter ends with a description of the development of the health sector in New Zealand from the 1850s when compulsory registration and training of doctors began.

1.2 Policy defined

A number of writers (Ham & Hill 1984; Hill (1982); Ham 1982; and Hill & Bramley 1986) have expressed difficulties with defining policy because of its complex nature. Leichter (1979) has made an attempt and defined policy as a "series of goal-directed actions taken by authoritative (usually governmental) actors" (pg 6). Authoritative actors are those in power. The important emphasis here is the notion of state activity. Le Breton and Henning (1961) have defined policy as a standing plan which takes into consideration political goals, objectives and strategies.

Policy, in this context, refers to public policy which is defined as "the actions and positions taken by the state as the overriding authoritative collective entity in society" (Hill & Bramley 1986:2). Public policy which includes social policy, economic policy and defence policy involves decisions made by the state which relate to society as a whole. There is, therefore, a connotation of collectiveness and community about public policy. Public policy does not deal with the private concerns of individuals and small groups, it deals with the concerns of large communities and society.

There are five important features of public policy (Hill & Bramley 1986). Firstly, public policy is about decision-making, particularly the patterns of decisions made over

time and in the context of previous decisions made. Secondly, public policy decisions are made by political actors. While political actors are not necessarily politicians, the making of policy decisions is a political act. Thirdly, public policies are about both "ends" and "means" i.e. "ends" policies focus on the goals to be achieved while "means" policies focus on the ways in which the goals can be achieved. Fourthly, public policies are contingent on the context within which they are made. For example, the extent of health service expenditure may be contingent on the economic conditions of a country. Fifthly, public policy is confined to matters over which the state has authority.

As a sub-set of public policy, some social policy is concerned with the collective needs of society by redistributing wealth to enable fair and just access to a variety of social services. The view that social policy deals mainly with redistribution is dependent on the philosophical underpinnings of policy-makers. Titmuss (1963:39) articulated this view of social policy as "all collectively provided services are deliberately designed to meet certain socially recognised "needs"; they are manifestations first, of society's will to survive as an organic whole and, second, of the expressed wish of all the people to assist the survival of some people". This view of social policy is underpinned by a collectivist, as opposed to a liberal, philosophy i.e. society has needs and a will and seeks to survive as an organic whole.

Titmuss (1973) has offered a prescriptive definition of social policy. In his view social policy has a positive role in influencing social values and relationships (Titmuss 1973). He has stated "social policy is not simply about therapy for the dependent but about how people interact; and ought most of all to focus on processes, transactions and institutions which promote an individual's sense of identity, participation and community" (Titmuss

1973:283). Thus social policy is concerned with the redistribution of resources, particularly to those who lack them, in an effort to promote the well-being of all members of society. The decisions about which resources are to be redistributed and who to form the basis of many social policy decisions. An important outcome of social policy decisions concerned with redistribution is the promotion of a sense of community.

1.3 Policy analysis: prescription and evaluation

Approaches to social policy analysis can be differentiated in terms of whether their focus is either (a) the development of a knowledge base upon which policy is constructed or (b) an evaluation of existing policies. Gordon, Lewis and Young (1977) have described the former orientation as "analysis for policy" while the latter orientation is described as "analysis of policy".

Gordon et al (1977) have elaborated further on the "analysis of policy". They maintain that "analysis of policy can take two different forms: (a) analysis of policy determination and effects which concentrates on examining the "inputs and transformational processes operating upon the construction of public policy" (pg 28) and its effects on various groups; and (b) analysis of policy content which examines the values, assumptions and social theories underpinning the policy process.

The analysis of social policy cannot be viewed as a simple undertaking as it requires the consideration of several aspects. Expert policy analysts have pointed out that policy analysis must be sensitive to the political and social environments (Leichter 1979; Hill & Bramley 1986); economic conditions and the products of other policies (Leichter 1979; Hill 1982). Ham (1982) has stated that actions and decisions are the proper focus of policy

analysis. This includes the actions and decisions or non-decisions of all "interested parties" in the policy-making process. Thomas Dye (1976 Cited in Ham & Hill 1984) has defined policy analysis as a description and explanation of the causes and consequences of government action.

Leichter (1979) has noted that public policy analysis involves:

- * the analysis of the intended purpose of state activity
- * the steps taken to enforce these intentions
- * the measures of their consequences and
- * an explanation of the similarities and differences in policies among political systems.

Ham and Hill (1984) describe policy analysis as a problem-centred activity which takes as its subject matter problems facing policy-makers with the view to finding solutions. They further elaborate "the purpose of policy analysis is to draw on ideas from a range of disciplines in order to interpret the causes and consequences of government action" (Ham & Hill 1984 pg 11).

Leichter (1979) maintains that all policies can be evaluated in terms of a combination of four factors: situational, structural, cultural/ideological and environmental. Situational factors refer to rather transient, impermanent and idiosyncratic events which may impact on policy-making. An example of a situational factor would be an event such as a relatively major earthquake. Structural factors refer to relatively unchanging elements of society and polity. Examples of these are the economic base and the political system. Because these are relatively unchanging or at least change more slowly, they tend to have a more predictable impact on policy. Cultural/ideological factors refer to the values which communities as a whole tend to espouse and include issues of ideology. Environmental factors refer to the events, structures and values that exist outside the

boundaries of a political system but still impinge on policy-making within a system. Examples of environmental factors include media pressure and international events, policies and agreements. Leichter's framework is used to guide the research in the present case study.

Hill and Bramley (1986) have stated that policy analysis "involves studying the continuing interplay through 'political action' (in the widest sense) between different policy goals" (pg 138). They view policy analysis as a cascade of activities "...in which concrete system outputs on the ground are determined by activities and interactions throughout the whole policy process" (Hill & Bramley 1986:138).

One form of inquiry in policy analysis involves the evaluation of existing policies or the evaluation of the process whereby policies are developed. The commonest technique used is the case study method (Hill & Bramley 1986). The case study can involve either a single case or the comparison of a limited number of cases and includes utilizing evidence from interviews with key actors and the review of documentary records.

1.4 Approaches to policy analysis

Two major contrasting theoretical approaches to policy analysis to be found within the current literature are: the pluralist approach and the Marxist view. The pluralist approach assumes that the policy process is open and subject to competition. Pressures from within and without the political system are exerted on the government and result in the choices made about which policies gain priority. Pluralist theory includes the recognition that there are powerful and powerless groups in society although these groups are not necessarily class related. In this context groups are usually described as elite or non-elite

(Hill & Bramley 1986). Some non-elite groups are so weak that their political participation is minimal while some elite groups are so strong that they are difficult to control (Mills 1956).

The Marxist view is that governments pursue policies which support the capitalist state. While Marx originally described the state as being in the control of the ruling classes and therefore policies which supported the state also supported those in power, this view has modified over the years. As government institutions have grown in size and power, there has been a concomitant rise of a powerful state bureaucracy (Weber 1947) with the emergence of a new public servant class (Djilas 1957). The state, then, is viewed as being an autonomous entity.

A pluralist account of policy is given by Hall, Land, Parker and Webb (1975) who used a systems model in their extensive analysis of social policy. Hall et al (1975) analysed case studies in an attempt to determine what gave priority to policy issues. They concluded that the progress of policies through the system depended on three criteria: legitimacy, feasibility and support. Legitimacy refers to whether or not the government considers that it should be involved with a particular policy issue (Hall et al 1975). Government involvement would depend on both internal and external factors. The internal factors refer to the political ideology at the time while external factors refer to public opinion and powerful interest groups. Feasibility refers to whether or not a policy option is likely to be successfully developed and implemented. Feasibility, therefore, is concerned with the availability of resources and the co-operation of administrators (Hall et al 1975). There are implicit value judgements to be made here just as there are in the other aspects of the policy-making process. Support refers to the political viability of a policy in terms of the degree

of power of supporters as opposed to that of non-supporters (Hall et al 1975). Hall et al (1975:483) state

Because policy change alters, or is thought to alter, some features of an existing distribution of power, influence, status or values, inevitably it will create some satisfaction and some discontent. The notion of the political feasibility of an issue is closely connected with its implications for this balance. Two considerations determine how it is estimated by authorities. The first is whose discontents and whose satisfactions are involved, and the second is the general state of the reservoir of support. (Emphasis in the original.)

Hall et al (1975) maintain that the "image" of an issue is important and influences its progress within a system. The relationship between the issue and developments or trends in society, for example, will affect its priority and the quality of the information available. Hall et al (1975) have pointed out that policy issues can attain priority because either the government or other interest groups have given it this priority.

Both pluralist and Marxist policy analysts employ some form of framework to guide the analysis of policy. Many frameworks rely on a systems model which implies inputs and the development of outputs or outcomes. This has led to the identification of some general indices of level of socio-economic development and convergence theories (Wilensky 1975). This approach has not been successful for cross-national analysis (Hill & Bramley 1986).

Knoepfel and Weidner (1982) developed a framework for policy analysis which attempted to integrate the features of both policy-making and policy integration. The framework was designed for a comparative study of air pollution policies. While it may be difficult to apply this framework outside that specific policy context, there are some general ideas which may be useful in other contexts.

Knoepfel and Weidner's (1982) framework can be conceptualised as an onion with a central core surrounded by concentric layers of skin. The analyst then attempts to analyse the fundamental dimensions of the policy issue utilising some form of check-list. This framework allows the integration of policy development with policy implementation. The analyst, then, examines the core and each series of concentric circles by attending to both the development and implementation of the policy. The core is the most problematic aspect of the framework because it is so central to the whole and is quite subjective. The analyst must consult with experts in the substantive field under study and obtain a high degree of agreement among them about the definition of the core. Knoepfel and Weidner (1982), for example, defined concrete air quality standards as their core. As Hill and Bramley (1986) have pointed out, however, to gain consensus on the desirability of clean air is one thing but to gain consensus on the concrete standards of air purity is quite another.

Knoepfel and Weidner (1982) utilised three separate systems for their check-list which essentially attempted to identify and analyse possible interest groups, namely: the socio-cultural or legitimacy system, the economic system and the politico-administrative system. This framework is useful as it allows the comparison of micro-issues about specific policies with macro-issues about the wider political contexts. The need to obtain a high degree of consensus about the definition of the core, however, is a serious flaw in Knoepfel and Weidner's (1982) framework (Hill & Bramley 1986).

As many writers have observed, the field of policy analysis is fraught with conflicting theories, alternative frameworks and contested issues. Any analysis of policy involves careful consideration not only of the overt and obvious variables but also the more covert underlying

philosophical assumptions embedded in the political and social variables.

1.5 The development of social policies

Social policies are developed in response to the demands and aspirations of communities about how society is to work. Social policies, therefore have to be seen in an historical context encompassing the social and political climate of the time.

Most Western societies are based on the concept of a Welfare State. These societies have a means whereby money, usually in the form of taxes, is collected and then used by the state to supply services and goods which society as a whole has identified as necessary and appropriate for the public good.

Political parties develop social policies which are deemed as desirable for society as a whole. Members of society are then given the choice of electing the political parties which will provide the most appropriate policies. This is what democracy is, the election of governments which will carry out the wishes of the members of society. While this account is too simplistic and general it does give a brief overview of the policy development process at this point. It should be noted, however, that there are many variables which influence the choice and direction of social policies.

As the amount of money which is collected by governments is finite and because members of society hold different values, the achievement of consensus in the development of various social policies is almost impossible. Therefore, decisions about which social policies are to be developed and why they are given priority have to be made by those with the delegated authority.

1.6 Types of policies

There are two broad distinctions which Anderson (1979) has made about social policies. There are substantive policies, those which broadly state the intentions and direction of political parties and there are procedural policies, those which are developed to implement the substantive policies. Substantive and procedural policies are, therefore, closely linked.

Procedural social policies define the provision of social services and should reflect the aims of broad, substantive policy decisions. Within a welfare state social policy decisions are made to determine the distribution of social services based on the concept of need (Soper 1981) which is both ambiguous and open to debate. There appears to be no consensus about what constitutes a social need (e. g. Maslow 1943; Williams 1974; Illich 1978; Springborg 1981; Soper 1981; Weale 1983; Doyal & Gough 1984;). It may, therefore, be more useful to replace the concept of need with that of social justice. Barry (1965) and Rawls (1972) used the term "procedural justice" which they maintained commanded near-universal support. "Procedural justice" refers to "fair play" or what the majority of members of society would deem to be just and fair. So broad agreement on the principles of "fair play" would lead to the development of substantive distributional principles. Such agreement, however, might be too difficult to achieve.

Up until the early 1990s there has been more of a consensus, in the area of health care, about what services should be provided and funded by the state (Cooper 1975; Culyer 1976). Health care policies, then, have tended to evoke more consensual community support than social policies in general. This situation may well change as the new health reforms being ushered in by the National

Government since July 1991 require the identification, by the community, of core health services (Minister of Health 1991). The core health services will be state funded for universal access i.e. the state will fund core health services and ensure that all community members have access to these core services. Those services not identified as "core" will not necessarily be funded by the state. The achievement of community consensus in the identification of core services could be difficult.

Social policies have important implications for the resulting distribution of social services and access to these. Anderson (1979) has identified three different forms that policy can take: distributive, regulatory and redistributive. Distributive policies are those, often based on need, in which, "...resources are allocated to assist particular groups, and where those seeking benefits are not in direct competition with each other" (Prunty 1984:5). Regulatory policies are those which, "...involve the imposition of restrictions or limitations on the behaviour of individuals and groups and reduce the freedom or discretion to act of those regulated." (Anderson 1979:128). Regulatory policies ensure that the system is hierarchical with power concentrated at the top. Embedded in these policies are the cultural values of dominant groups in society. Redistributive policies are those which attempt to redistribute resources in favour of the disadvantaged groups in society. Anderson (1979:130) maintains that redistributive policies involve, "...deliberate efforts....to shift the allocation of wealth, income, property or rights among broad classes or groups of the population."

Lowi (1972) developed an approach which has been widely used to classify the different types of policy. He identified four categories of policy in relation to government as follows: distributive, redistributive, regulatory and constituent. In distributive policy the

government is involved in distributing new resources whereas with redistributive policy the aim is to shift resources from some individuals to others. In regulatory policy the government aims to prevent and control individual activities while in constituent policy it is involved with setting up agencies and generally adjusting its systems of government.

Austin (1983) has categorised policy in terms of the services provided rather than into policy types as in the above classification. He maintained that all policies would fall into one or a combination of his three "service" categories. His three categories are as follows:

- (1) Universal services. These are services which are individually consumed but collectively provided for universal utilisation. It is assumed that universal services create a public good and therefore benefit the community.
- (2) Redistributive services. These services provide protection for vulnerable individuals e.g low-income or disabled etc.
- (3) Behaviour change/social control services. These services are designed to change people's behaviour in some way so that they and the community can "benefit" (Austin 1983). "Benefit" is described as accruing to the community as a result of the change in behaviour of certain individuals "whose behaviours are considered to have significant consequences for the community as a whole" (Austin 1983:350).

Hill and Bramley (1986) have questioned the efficacy of Lowi's (1972) distributive category, maintaining that "most distributive policies are in fact to some degree redistributive" (pg 143). A similar criticism has been levelled at Austin's (1983) Universal services category, as most collectively provided services are generally based on

some form of redistribution of resources (Hill & Bramley 1986).

Social policies are often regarded as mainly redistributive in nature. Redistributive policies are based on notions of equity and social justice, and aim to redress some of the inequities in society (Hill & Bramley 1986). In the area of health care policies, the aim is to ensure all members of society have equal access to health care services. The categorisation of policies as redistributive has been found to be problematic by some social policy analysts who see redistributive policies as inherently regulatory (Piven & Cloward 1972). This contention further clouds the issue of categories of policy.

While the above typologies have been developed to assist in the process of policy analysis, it is recognised that most policies will not necessarily fit into these discrete categories. Most policies will often be mixed types.

1.7 Social policy and economic development

Social policy cannot be seen in isolation from economic policy. Hill (1982) has stated for example that "social policy should be seen as dependent on or even a derivative of economic policy" (pg 7). Social policies are not possible without a resource base. He makes the point that the key internal political issues are, who controls the economy and how the rewards that stem from a country's industrial achievements are to be distributed (Hill 1982).

Hill (1982) has further noted three significant implications for social policy as follows:

- (1) the main determinants of welfare are economic

- (2) the government's role in diverting resources into social policies is closely related to the role it plays in the management of the economy and
- (3) social policies will be determined by the views about the way that the economy does or should operate (Hill 1982).

It is generally accepted that there is a degree of correlation between economic development and social policy developments (Wilensky 1975; Leichter 1979; Raffel & Raffel 1987 and Hill 1982). In other words there appears to be some contingent relationship between the economic wealth of a nation and the comprehensiveness of its social policies. This association, however, is not necessarily causal (Carrier & Kendall 1977; Higgins 1981; Fuchs 1979).

In the area of health care, it has been quite clearly shown that there has been an international trend towards increasing costs. Raffel and Raffel (1987:10) have commented "escalation of health care spending has been an international phenomenon which has transcended the different policies and institutional arrangements of individual countries...". While there may be no causal relationship between economic development and social policy development there has nevertheless been a move to reduce public expenditure in New Zealand at the same time that the economy is restructured (Treasury 1987).

1.8 Health expenditure in New Zealand: the neo-liberal solution

In New Zealand, health expenditure, as a proportion of Gross Domestic Product (GDP), rose from 7.0 percent in 1980 to 7.4 percent in 1989 (Department of Health 1989). This rise in health expenditure was not confined to New Zealand. In 1987 Raffel and Raffel (1987) calculated an arithmetical average of twenty countries and concluded that health

expenditure rose from 4.0 percent of GDP in 1960 to 7.1 percent in 1984. While there are undoubted problems with comparisons between different countries and different methods of cost counting etc, the point is that there has been a definite trend towards increased expenditure in health care. The increased government expenditure in the public sector has been equated with an increasing role for the state in society as a whole (Leichter 1979).

In New Zealand, the Treasury (1987) in its brief to the incoming government commented that public expenditure was too high and measures would need to be instituted to contain this expenditure. Further, Treasury maintained that the current social policies were not directed at those most in need. Treasury stated

The lion's share of income support and other social policies is in fact devoted to schemes that are not focused on those in need. Education and health spending are not targeted towards improving the access of low income people but instead are directed to the maintenance of major public sector monopolies. (Treasury 1987:7).

Treasury attributed a great deal of this high expenditure to poorly designed social policies and low quality management of public institutions. Their advice to the government was to reform the public sector. They commented

The influence of the public sector is so pervasive and the impact on the rest of the economy through the size of the tax burden (and the consequential adverse effects on incentives to produce and work) so great that the reform of the public sector seems clearly the single most important item on the Government's agenda for the next three years. (Treasury 1987:8).

A reaction to this increased expenditure has been a move to contain costs (Raffel & Raffel 1987). Cost containment is apparent in the whole area of public policy, not just in the health sector (Easton 1989). Crocombe, Enright and Porter (1991) have stated "We must determine what types and levels of government spending are sustainable, realistic and fair for the wider community. In particular, we need to reassess the magnitude and extensiveness of the Welfare

State. We simply cannot afford the present system" (pg 172).

1.9 A critique of the neo-liberal approach

The views of both Treasury (1987) and Crocombe et al (1991) reflect a neo-liberal perspective. The values underpinning neo-liberalism emphasise, "the operation of free market forces, minimal state interference, proprietarian rights and laissez faire attitudes." (Peters & Marshall 1988: 681). In *The Royal Commission on Social Policy* report Peters and Marshall (1988) pointed out that the substantive policy direction proposed by Treasury (1987) tends to divorce the individual in society from his/her primary and secondary social groups. They state

In Lockean fashion the individual is seen as standing separate from and prior to society. The so-called 'free' individual is regarded as the basic unit of political order and the safeguarding of the individual's life, liberty and property as the state's fundamental purpose. There is a bias towards a minimal state for any extension of the role of state over and above these ends is regarded as both unnecessary and dangerous. (Peters & Marshall 1988: 681).

The promotion of the importance of the private individual over that of the public community is seen as problematic because the result is a view that social well-being is a matter of individual choice (Peters & Marshall 1988). In addition, there is no recognition of the reliance that individuals have on their own social environments, particularly for nurturing and conditioning of the individual in his/her definitions of self.

The Royal Commission on Social Policy advocated a collective view rather than an individual view in social policy. Peters and Marshall (1988) state

As New Zealanders we face the imminent choice of becoming either, individual consumers of welfare who

'buy' our health, education and care or, members of communities who collectively identify local social problems and act in educated concert to solve them. If New Zealanders are to ensure that the standards of a fair society, as identified in the Commission's terms of reference, are met such that there is a fair distribution of wealth, that everybody can participate in and have a sense of belonging, and that there is a general acceptance of, and respect for, cultural diversity, then the notion of community and its practical embodiment in social policy must be accorded a significance equal to the status presently advocated for the notion of the individual. (Peters & Marshall 1988: 680).

The market philosophy advocated by the Treasury (1987) brings with it its own language. One no longer refers to patients within the health sector one refers to consumers. Consumers are individuals who consume services on the basis of ability to gain access to these. This insidious change of language within the health sector brings with it a whole new perspective on health services and more importantly on the welfare state. The use of the term "consumer" instead of "patient" implies individualism at the expense of the whole community (Peters & Marshall 1988). Thus the individual is given priority over the community and the welfare state is deemed to be superfluous.

1.10 The development of the welfare state in New Zealand

In order to understand the links between social policy and economic policy, one needs to be aware of the different theories which exist and attempt to explain the existence of the welfare state.

The origins of the welfare state have been explained in terms of egalitarianism (Hill & Bramley 1986); the state was concerned to provide for the poor. Sutch (1966) has described New Zealand society as a migrant people striving to attain security. This quest for security permeates public social policy in New Zealand (Shirley 1986).

The state occupies a dominant role in society and has a great deal of power to influence many areas of social life. The state is expected to respond to society's demands for more favourable standards of living (Clements 1986) and is, therefore, intimately involved with the economy. In New Zealand this involvement has demanded constant state intervention because the economy is relatively undiversified and the international markets within which New Zealand competes are quite volatile (Clements 1986).

Other theorists emphasize the development of the welfare state in terms of the concept of social control i.e. to prevent unrest and to legitimate the capitalist system. Marxist theories of the state take two approaches. Firstly the state is conceived of as the instrument of the ruling class. The state then operates to further the cause of the ruling class (Marx & Engels 1848/ 1967). Secondly, the state is not seen as being allied with or fostering the particular interests of specific classes but simply sanctions and protects a set of institutions and social relationships necessary for the ruling class to remain in power (Marx et al 1848/1967). The result of both approaches is the preservation of capitalism.

Capitalism has a tendency to result in social inequality as disparities exist between those who become owners of capital and those who only have their labour to sell (Shirley 1986). Such inequalities can result in social unrest and discontent. In an effort to ameliorate some of these inequalities the state tends to become involved in the provision of some social services. The state's involvement in education and health, for example, has been described as serving a legitimatory function (Wolfe 1977). In other words state involvement in the areas that are not effectively dealt with by the market serves to reduce public discontent and enables the state to alleviate some of the adverse effects of capital accumulation.

Legitimation is, "...what persuades the mass of the population that the status quo is the common sense way to organise society: it converts power into authority. Traditionally, the capitalist economy is legitimated through common sense beliefs such as 'the protestant work ethic',.." (Codd 1990:192) In other words, members of society are socialised into accepting that the state operates in certain ways which then become imbued with some sort of traditional authority. Such common sense practices then become accepted as the norm. In advanced capitalist systems legitimation of the state is largely achieved through "scientific-technical rationality" (Habermas 1976). All political problems are changed into technical ones requiring technical, scientific rationalisation or solutions (Fay 1975).

The conversion of ideological problems to technical, scientific ones tends to depoliticise members of society because social operations become 'captured' by technical experts and bureaucrats (Codd 1990). Thus, only those with the requisite expertise have access to the policy-making process. Consumers would be perceived as not having the requisite expertise to develop policy for the state.

New Zealand is a capitalist state founded on the notion of "competitive self-interest of individuals maximising the factors of production, namely land, capital and labour..." (Shirley 1986:242). In the early 1900s as the country's natural resources became depleted, the foundations were laid for New Zealand's agricultural industries. The free market philosophy of that time resulted in serious social inequities (Shirley 1986). There then resulted a movement towards the notion of social security as income inequalities began to be considered economically dysfunctional (Shirley 1986).

The Social Security Act of 1938 was passed by the Labour Government and provided for a free national health service

that was to be accessible to all New Zealand residents. Health therefore became a responsibility of the state and a charge to the nation. The medical profession refused to agree to the notion of universality as it would mean being employed and overseen by the state. The Government, then, agreed to allow the medical profession to retain the right of private appropriation. This is an example of the contradictory nature of this social policy (Shirley 1986). On the one hand the Social Security Act of 1938 was designed to ameliorate the problems resulting from the capitalist mode of production but on the other it supported capitalism.

1.11 Bureaucracies and policy development

Traditionally policies are developed and administered by bureaucrats or public servants who are employed by state institutions or organisations such as the Department of Health and the Ministry of Education. The growth of state institutions in the administration of social policy initiatives has resulted in burgeoning bureaucracies (Thompson 1983). As Weber (1947) foresaw, bureaucracies are here to stay. Some theorists have observed that with the expanded activity of the state is a concomitant growth in the public sector which retains a self-interest in maintaining and further expanding the business of the state (Tullock 1976; Offe 1984; Cawson 1982 and Alford 1972).

The professionalization of state administrators and policy-makers is one outcome of state expansion. This trend is potentially undesirable because there is a tendency for bureaucrats to "use their professional standing to conceal the moral and political choices inherent in their methods...." (Thompson 1983:102). As Thompson (1983) further points out, the "professional" bureaucrat adopts a collegial form of accountability which is problematic as it fosters paternalism and ill serves democracy.

Professional bureaucrats, particularly in education and health often justify their contribution to policy-making on the grounds that they are experts in their fields (Hill & Bramley 1986). In the health field which deals with issues of life and death, such claims by professionals to autonomy and the right to participate in decision-making is compelling and difficult to resist (Hill & Bramley 1986). This situation invests the professionals with a great deal of power (Wilding 1982).

1.12 Consumers and participation in policy development

The bureaucrat's monopoly on social policy development has not gone unchallenged. There is an increasing demand for more public involvement in the policy-making process; the consumer is demanding the right to participate in the decisions that are made in the social policy area (Richardson 1983). Consumers have voiced the opinion that bureaucrats have become more removed from them and hence policies reflect the needs and wishes of bureaucrats rather than consumers (Richardson 1983). For their own reasons, service providers have, up to a point, also welcomed the opportunity to involve consumers in the policy-making process. As Richardson (1983:99) stated, "Consumers have advocated participation in order to achieve their particular ends and the service providers have similarly welcomed it in order to serve theirs. The very uncertainty of its impact has enabled a common rallying call."

Consumer participation in the development of social policy has gained impetus over the last decade. It became fashionable to talk about including the community in determining policy (Richardson 1983). In Britain, participation became an issue in the 1970s. When the National Health Service was reorganised about this time, it included strategies for consumer participation.

Participation was viewed as a convenient way of solving wider political problems. As Klein and Lewis (1976:13) have stated

And although the plans for reorganisation had begun to evolve in the mid-sixties, the era of interest in planning, they had been completed in the 'seventies, the era of interest in participation. The political problem, therefore, was how to best square the circle of elitism and populism: how to reconcile the emphasis on centralised planning with the currently fashionable rhetoric of local participation.

While both consumers and service providers may have welcomed the era of consumer participation in policy-making, it is debatable whether both have the same ends in mind. Consumers are motivated to ensure that their views are taken into account while service providers appear to be motivated by a variety of aspirations (Richardson 1983). Providers have been keen to hear the views of consumers so that they could alter their practice in line with consumer expectations (Richardson 1983). In addition, some providers view the inclusion of consumers in the policy-making process as an opportunity to influence them about the necessary courses of action (Richardson 1983). In other words, providers have sought to dominate consumers in the policy-making process.

Richardson (1983) maintains that consumer participation in policy-making can be viewed from two perspectives. The first perspective is on the policy decisions made by consumers. Some claim that, by participating in policy-making, consumers have more influence over policy decisions. Others have claimed the opposite effect i.e. participation in policy-making results in the socialisation of consumers to accept the professional and/or bureaucratic view. The second perspective is on the participants themselves and the effect that participation in policy-making has on them (Richardson 1983). In broad terms participation can be divided into:

- (1) the process of participation and

(2) the substantive consequences of participation (Richardson 1983).

1.13 The process of participation

The focus on the process of participation assumes that the participants have rights to be heard. For example it is assumed that those who will be affected by policy decisions have a right to influence their outcome and therefore should be included in the decision-making process. Consumers, therefore, should be the judge of their own interests (Parker 1975). There is a contrary view that while consumers may well be the beneficiaries of services, if they do not directly bear the costs of these then they should not necessarily have any over-riding right to participate in framing policy (Friedrich 1975).

While it can be asserted that consumers have the right to participate in policy development the choice of representative consumers is more problematic. That is, who should be representative of consumers? An additional problem is the degree of weighting which should be placed on consumer input a propos that of the professional or bureaucrat.

1.14 The substantive consequences of participation

Participation is claimed to benefit the well-being and behaviour of participants. In addition participation is claimed to affect the decisions taken. Consumers, for example should participate in making decisions which affect their everyday lives because they have a fundamental right to self-fulfillment and freedom. As Marcuse (1970 Cited in Richardson 1983:55) has stated, "The social theory of democracy.....argues that it is of the essence of a truly human life that certain decisions are made by the

individual himself, not because they are better decisions.....but because the 'control of decisions that affect a man's life' must be his before a man can be free." By promoting participation in policy-making, society is expressing its faith in the dignity and worth of the individual.

Participation can also enhance the development of an individual's capacities. The experience of participation improves an individual's skills and self-confidence and thus, self-esteem. Experienced participants will also be better able to participate and contribute positively in the future.

Smith (1975) does not agree that participation necessarily results in the positive development of participants. He states

Nor is participation necessary for development of one's sense of self-esteem, for many persons who do not participate are not racked by doubts about their worth and doubtless many who do participate are prey to such doubts. (pg 139).

This does not mean that participation cannot contribute to a person's development, merely that development may not necessarily be an outcome of participation. Considering the range of experiences encountered during participation, it would be reasonable to expect some form of personal development. Development is possible for both consumers and professionals. Professionals, exposed to the thoughts and attitudes of consumers during participation, may well learn a great deal.

A further claimed consequence of participation in policy-making is that individuals gain a better appreciation and understanding of their environments. Richardson (1983:58) states "By taking part in the processes of policy-making, individuals are said to develop a heightened sense of social integration. This means that they will not only ascribe greater legitimacy to their political institutions

but also will prove more willing to comply with them." The view that participation leads to greater social integration assumes that participant consumers have little sense of integration prior to their involvement and that the professionals are all concerned to foster this sense and will automatically be successful (Richardson 1983). This view is questionable as a heightened sense of social integration could be described as social control because it serves to maintain the existing social order. This social control tends to legitimate the state institutions and thus serves to ameliorate the problems of legitimation.

Participation can result in social control as participants become aware of the constraints facing the professionals and bureaucrats. Thus, participation

...can force, or educate, the participants to gain an awareness of governmental problems and policies and this will not only inhibit the public from pressing for solutions to their own problems, but will also enable the authorities to legitimise their decisions with the stamp of public approval. (Dearlove 1974:37).

Child (1984) maintains that control is a notion which is surrounded by ambiguity because of its close association with power and influence. The notion of control is ambiguous because not everyone shares the same goal. Thus control, "...is also a process in which there is resistance and counter-control in pursuit of conflicting objectives." (Child 1984:136).

According to Richardson (1983) some theorists argue that participation does not result in social control but enables participants the opportunity to press for social change. The view that participation leads to reduced social integration or control assumes that participant consumers are politically passive prior to their involvement but will be galvanised into political action by their participation. This view also assumes that the professionals will be willing to foster such a change. These assumptions tend to be simplistic as it is unlikely that the concerns of both factions will be monolithic. It is more likely that there

will be a range of interests among participants which will be mobilised by the act of participation.

Some theorists maintain that consumer participation will not result in social control because the very act of participation shifts more power to consumers. Thus the power relations between consumer and professional policy-makers is balanced out when both factions sit on policy-making groups. As Richardson (1983:63) states "Consumer participation, then, is an important device for shifting the balance of power in favour of the consumer."

It has been claimed that participation can work against consumers by decreasing their power and furthering the interests of service providers at the expense of consumers (Ward 1973). Thus participation is viewed as a mechanism which is used by the powerful to subdue the powerless. As Cockburn (1977:97-98) has stated, "Whereas the firm tries to reduce market uncertainty by controlling demand, by intelligent advertising and judicious product design, the state uses participatory democracy and 'the community approach'." Thus participation tends to strengthen the position of service providers by legitimating it while claiming that consumers have been consulted. Saunders (1980:284) has claimed that when minor concessions are made to consumers, such gains are, "...highly charged symbolically, for they aid the legitimation of the political system itself by underlining the prevailing definition of it as pluralistic and accountable."

The choosing of consumer representatives who can speak for consumers as a whole is a problem. Some theorists maintain that there is a tendency for consumer representatives to indulge their own ideological and personal prejudices when engaged in policy development (Friedrich 1975). Others maintain that those who will represent consumers will inevitably be the articulate middle-class and will thus be unrepresentative (Simmie 1974). A further complication in

the quest for "true" consumer representation is the position that participants become unrepresentative through their participation (Richardson 1983). As Brown (1975:277) has commented "The informed tend to become the committed. We may need informed laymen to keep an eye on the specialist, and uninformed laymen to keep an eye on the informed."

The issue of representativeness of consumers is a problem which is difficult to resolve. Richardson (1983:127) has commented

...those who participate are likely to be unrepresentative of the very population for whom they are supposed to speak. ...the decisions reached are likely to have some benefit for the involved, but at the expense of those who are excluded. Indeed, the uninvolved may be doubly hampered because the existence of participatory arrangements appears to give them a fair hearing.

She further states, "Consumers....private interests cannot be equated with the public at large." (Richardson 1983:128).

The policy-making group which includes both providers and consumers can be described as utilising a bargaining process, where both sides have some common aims and also some divergent aims. The policy-making group, thus, has the opportunity to negotiate the divergent aims of both these groups of individuals with the aim of achieving some form of consensus.

While many claims are made about the positive aspects associated with consumer participation in social policy development, Richardson (1983) has rightly pointed out that

...the consequences of participation are highly unpredictable. One cannot assume particular results on the basis of either the intentions of the participants or the specific structures through which they are involved. Furthermore, because of the complex nature of the interests mobilised by participation, one cannot even say whose interests are best served. (pg 72).

The involvement of consumers in the development of policy, brings a whole new set of aims and considerations, adding these to the pre-existing ones of service providers. The goals of both factions may be strictly congruent with one another but this is quite unusual (Richardson 1983). Conflicts and controversy over policy decisions should be expected.

So the inclusion of consumers in the policy-making process has some support. Whether consumers have an impact on policy is more debatable. Their inclusion in the policy-making process may well be a subtle form of legitimation.

1.15 Health care in New Zealand

Consumers have not traditionally participated in the development of social policies, including health policies, in New Zealand. Health policies have been developed by bureaucrats within the health care system which has been dominated by service providers, particularly the medical profession. The health care system in New Zealand is based on the biomedical model with the result that "health" is defined as, "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (World Health Organization 1947:1 - 2). The biomedical model is based on science; the foundation of medicine rests on the causal relationships between diseases and agents (Blattner 1981) and is widely accepted within the health sector.

The medical model relies on morbidity and mortality statistics to determine the health and health needs of the population. As Davis (1986) has pointed out, the reliance on such statistics does not give us the whole picture, in terms of health, because it does not include factors such as quality of life. These statistics give only an

approximation of changes that occur in the patterns of disease in a population.

The use of rational science to underpin much of health policy to date is a reflection of the dominance of medical professionals in policy-making in the health sector. Arguments based on rational science tend to have priority over the declared wishes of consumers and result in their disempowerment (Habermas 1976). As Codd (1990:192) has stated "Social institutions are rationalised by technical experts and political problems are converted into technical ones with technical solutions." Rational science is compelling and difficult to refute, particularly by lay people who are deemed to be devoid of the requisite knowledge. Thus morbidity and mortality statistics have been used at the expense of aspects such as quality of life. The inclusion of consumers in policy development could bring an alternate view to the medical one inherent in health policies in New Zealand.

1.16 The development of the health sector in New Zealand

New Zealand's health care system originated in the private sector like most other health care systems around the world. Medical practitioners set up their own practices around the country and were relatively free to do as they pleased. It was not until the 1850s that they were required to be registered and undergo some form of training (Mckenzie 1974). Hospitals, founded by religious orders in the main, existed at this time but their clientele was mainly restricted to the needy, the mentally ill and the elderly. Concomitant with the introduction of hospitals was the inception of the training of nurses in 1884 in Wellington and Auckland, although there were no regulations to govern this training until the enactment of the Registration Act for Nurses in 1901 (Department of Health 1951). On the whole, New Zealand's administration of

public health during the nineteenth century was not comprehensive or particularly effective (MacLean 1964).

Towards the end of the century, however, the fear of the plague resulted in the establishment of the Department of Public Health with the passing of the Public Health Act of 1900 (MacLean 1964). The Department's initial focus was on the prevention of plague within the country. Attention was also given to establishing and improving methods of sanitation; encouraging widespread vaccination against smallpox and controlling tuberculosis (MacLean 1964). Other public health measures which focused on health promotion resulted in the establishment of midwifery training and registration and the founding of Plunket nursing in 1906 (Department of Health 1951). In 1909 a Chief Health Officer, Dr T. H. A. Valintine, was appointed who had a personal back-ground and interest in hospitals. Thus the Department of Public Health became preoccupied with hospitals to the detriment of preventive medicine (MacLean 1964). This trend was to continue unabated until the 1930s.

The Department of Public Health became the Department of Health with the enactment of the Health Act of 1920. This Act saw the transference of many powers that were previously held by local authorities to the newly established position of Director-General of Health within the Department of Health (MacLean 1964).

Early public health measures concentrated on the environment and tended to include the whole community. By 1927, "...public health was beginning to acquire a more personal character. Good health could not be achieved by community action alone - the personal factor was beginning to assume greater importance" (MacLean 1964:27). Concomitant with this fundamental shift in the perception that public health was also a personal matter, was the policy of decentralisation of public health administration

to the districts (MacLean 1964). Thus it was deemed inappropriate for the centrally sited Department of Health to administer public health programmes around the country. It was proposed that administration of public health programmes should occur as near to the districts as possible. Thus, several district offices were established around the country to oversee administration of public health programmes in their own areas.

It is interesting to discover that decentralization was substantive policy within the health sector as long ago as the 1920s because it is often touted as a recent policy decision. This finding supports Miklos's (1973:1) statement that, "...the decision to either centralize or decentralize by any organization today may still be more a random occurrence or a desperation move than a rational response to a particular set of problems." Decentralisation has been proposed as a remedy for many organizational ills (Miklos 1970) and was vigorously advocated by Treasury (1987) in its quest to limit the role of the state in the social policy area.

1.17 Summary

In summary social policy, a sub-set of public policy, involves state activity on behalf of and for the good of society as a whole. Social policy, thus, connotes collective activity based on community consensus. Policy analysis is a form of inquiry leading to; either the acquisition of knowledge for the development of policies or the evaluation of existing policies. The evaluation of policies is normally guided by some form of model or framework. For example, Leichter (1979) developed a useful framework for the evaluation of policies in terms of a combination of situational, structural, cultural/ideological and environmental factors while the case study method is the commonest technique used.

Two broad theoretical approaches to policy analysis are the pluralist approach and the Marxist approach. The pluralist approach which includes neo-liberalism assumes that the policy process is open and subject to competition. The Marxist view is that governments pursue policies which support the capitalist state.

In their account of policy, Hall et al (1975) identified three criteria which determine policy priority, namely: legitimacy, feasibility and support. Knoepfel and Weidner (1982) developed a framework for policy analysis which was conceptualised as an onion and included a check-list system similar to Hall et al's (1975).

There are broadly two types of policy: substantive and procedural. While substantive policies indicate broad intentions, procedural policies are designed to implement substantive policies. Policies have been further categorised as: distributive, regulatory, redistributive (Anderson 1979); and universal services, redistributive services, behaviour change/social control services (Austin 1983). Most policies are not discrete types but tend to be mixed types.

It is generally accepted that economic development and social policy developments are correlated. While public health expenditure increased in the 1980s, there were moves to halt this. Treasury (1987) advocated both the development of social policies which targeted services to those in need and the upgrading of the management of public institutions. Peters and Marshall (1988) criticised the neo-liberal views underpinning Treasury's recommendations and advocated a collective rather than an individual view in social policy.

The origins of the welfare state can be explained in terms of either egalitarianism or a means of social control and

legitimation of the capitalist system. The state is expected to respond to the needs and aspirations of the members of society and its survival depends on its popular support which is acquired via legitimation. Legitimation is achieved through scientific, technical rationality. Thus, political and ideological problems become technical ones to be solved by technical experts.

New Zealand has a welfare state which has grown concomitantly with state institutions. The expansion of state institutions brought with it the professionalization of bureaucrats who captured and monopolised policy-making. By the 1980s there was a move, for a variety of reasons, to include consumers in the development of policies. Consumer participation has been claimed to benefit consumers and service providers. On the other hand, consumer participation may serve to influence consumers into adopting the views and attitudes of service providers and thus result in the legitimation of the political system.

Health care in New Zealand is dominated by medical professionals and is based on the biomedical model of health. Morbidity and mortality statistics are the measures utilised within the medical model of health to determine the health and health needs of the population.

The development of the health sector in New Zealand saw the regulatory registration of medical practitioners in the 1850s and the founding of hospitals by religious orders. The fear of the plague in the 1890s prompted the establishment of the Department of Public Health in 1900. In 1920, the Department of Public Health became the Department of Health with the establishment of the position of Director-General of Health. This circumstance led to centralisation of power vested in the Department of Health. By 1927, however, centralisation gave way to devolution as public health administration offices were established in the districts.

This chapter has provided the reader with information about many issues surrounding policy, policy analysis and the political and ideological aspects which impinge on the development of social policies. It has also introduced the reader to Leichter's (1979) framework which is utilised in this present case study.

The process of development of the NCSP policy is the focus of interest in this thesis. The next chapter provides a chronological history of the events leading up to the establishment of the NCSP policy-making group, the Expert Group.

CHAPTER TWO

THE ESTABLISHMENT OF THE NATIONAL CERVICAL SCREENING PROGRAMME: A HISTORY OF EVENTS

2.1 Introduction

This chapter provides the reader with an historical account of the events which led up to the establishment of the NCSP in New Zealand. Cervical screening is a simple health check for women which has been commonly practised for about thirty years. Cervical screening involves the removal of cells from the cervix for examination and early detection of abnormalities. Cervical screening, a preventive health check for women which is usually carried out by a health professional, is widely advocated as desirable. As early as the 1960s there was interest in the efficacy of cervical screening on a population-wide basis. Some medical professionals, the Cancer Society and more recently the Ministry of Women's Affairs were interested in the development of a cervical screening programme for women. The motivation for this interest was a recognition that cervical cancer morbidity and mortality in New Zealand was not declining.

An event in June 1987 put cervical cancer and cervical screening firmly in the spotlight. An article appeared in Metro magazine about experimental research at National Women's Hospital in Auckland. This was the beginning of a chain of events which eventually saw the establishment of the NCSP. The media exposure of controversial research at National Women's Hospital culminated in a Ministerially appointed Commission of Inquiry.

This Commission of Inquiry, the subject of intense media interest, lasted for just over a year and produced *The Report of the Cervical Cancer Inquiry* in July 1988 which recommended the establishment of a NCSP. This recommendation was accepted by the Government and the Department of Health was given the task of defining the requirements for a NCSP. Progress in defining the requirements for a NCSP appeared to be slower than the Minister of Health desired. She, therefore, appointed a Review Committee to provide her with recommendations about the establishment requirements for a NCSP.

The Review Committee produced its report in November 1989 and recommended the urgent establishment of an advisory committee to provide advice to the Minister of Health on the implementation of a NCSP. This advisory committee was established in December 1989 and comprised professional and consumer representatives who together developed the policy for the NCSP.

2.2 Cervical Screening

Cervical screening is a health check for well women which has as its objective the prevention of cancer of the cervix by early detection and treatment of abnormal cervical cells. Cervical cells are obtained via cervical smear tests, commonly known as Papanicolaou tests and involve the removal of cells from a woman's cervix for the detection and early treatment of any abnormality. The cervix is accessed via a woman's vagina using a speculum. The speculum holds the vagina open so that the cervix may be viewed and gently scraped with a wooden spatula or cytobrush to obtain a specimen of cells.

A cervical smear test and the consequent treatment of any abnormality is a widely accepted method of preventing cervical cancer (Skegg, Paul, Seddon, Fitzgerald, Barham &

Clements 1985)¹ . In other words, it is the precursors of cervical cancer which are treated prior to the advent of cancer itself. The cervical smear test is therefore rather unique as it is the only known method, apart from stopping everyone smoking, that has the potential to prevent cancer (ICRF Co-ordinating Committee 1984).

Cervical smear tests are performed in order to assess the quality of the cervical cells. The majority of cervical smear tests show normal cervical cells which do not require treatment. However, from time to time, abnormal cervical cells are detected which often require treatment so that the cervical abnormalities do not develop into cancer. Cervical abnormalities are broadly categorised in ascending order of severity: mild dysplasia, moderate dysplasia, severe dysplasia, carcinoma in situ (pre-invasive or pre-malignant) and finally invasive carcinoma or cancer. Carcinoma in situ, while pre-invasive, is thought to have the propensity to develop into cervical cancer (Cartwright 1988).

The Collins English Dictionary defines dysplasia as, "abnormal development of an organ or part of the body" (Hanks 1979:458). Dysplastic cervical cells, therefore, have developed abnormally for some reason. Cells can develop abnormally as a result of infections or as an inflammatory response to other agents. The danger is that abnormalities will become more severe and progress to cancer. The existence of cancer with its associated implications is potentially fatal. Hence the desirability of treating abnormalities before they become cancerous.

2.3 The Years Before Cartwright

Cervical screening was and is a personal service involving individual women but due to a better understanding of the

¹ This article is often referred to as the "Skegg recommendations".

relationship between early cell changes and cervical cancer there developed an interest in organising cervical screening on a population-wide basis. During the years 1962-65, cervical screening trials were conducted in the North Island (McIndoe 1964; Bayertz 1965). This was an initial attempt to research the efficacy of cervical screening on a larger scale than had been done previously. It was around this time that the value of cervical screening was being questioned by Professor Green at the Medical School of the University of Auckland (Adams 1991).

Green's eminent position within the medical fraternity in New Zealand had a powerful impact on the medical practice of cervical screening and the treatment of abnormal cervical smears in the country (Adams 1991). Thus cervical screening practice, nationally, depended very much on the perspective of individual medical practitioners. The result of this was that, where cervical screening was practised, it was opportunistic in nature. That is to say, women were offered cervical smears if and when they visited their doctor or Family Planning Clinic for other reasons.

At that time cervical screening was not organised within general practice. General practitioners very seldom provided call or recall services to their patients i.e. women were not invited to make an appointment for an initial cervical smear or reminded, after a suitable interval, that they were due for another cervical smear. A woman had to pay her general practitioner a consultation fee when she had a cervical smear. This fee was partially subsidised by the General Medical Services subsidy. In addition, the laboratory fee for reading the smear was fully subsidised by the government. Any follow-up of abnormal smears within the Public Health Sector was again fully subsidised by the government.

Although cervical screening was being questioned by the Auckland Medical School, there was sufficient evidence from

overseas which supported the efficacy of screening as a means to reduce the morbidity and mortality associated with cervical cancer (Clarke & Anderson 1979; Aristizabal, Cuello, Correa & Haenszel 1984, both cited in Skegg et al 1985). There was medical support for cervical screening in New Zealand, particularly from the Otago Medical School and the Cancer Society.

By the 1980s it became apparent that, nationally, cervical cancer morbidity and mortality was not decreasing, in spite of cervical screening practice (Skegg et al 1985). There was little information about the reasons for the lack of success in this area (Paul 1987b). However, the disorganised nature of cervical screening within the country was thought to be one reason behind the lack of impact on the morbidity and mortality statistics (Skegg et al 1991). Other reasons included; poor coverage of the population at risk (Grace 1985), problems with follow-up and referral of abnormal smear results (MacLean, Lay, Kelleher & Carnelio 1985) and problems with facilities for diagnosis and treatment in some parts of the country (Department of Health 1986).

The lack of success, in terms of reducing the morbidity and mortality associated with cervical cancer, prompted the Cancer Society of New Zealand (Inc) to convene a meeting with the Department of Health in November 1985. The meeting covered the topics: proposed screening intervals; strategies to increase screening coverage, particularly of those at risk; improvement of facilities for screening; improvement of quality control of smears and the establishment of a national cervical screening programme. The report of that meeting (Department of Health 1986) was disseminated widely in an effort to ascertain the views of other health professionals, particularly about: a) the need for a nationally organised programme and b) the establishment or upgrading of doctors age/sex registers.

Skegg et al (1985) were of the opinion that an organised screening programme should be established in New Zealand with the view to ultimately reducing the mortality rate associated with cervical cancer. They noted that there appeared to be overscreening of some women but this was not emphasised as a particular burden on Vote:Health until 1991 (Bonita & Paul 1991). Overscreening was defined as screening women who had normal cervical smear histories more frequently than once every three years.

The report of the November 1985 meeting (Department of Health 1986) in the Department of Health drew many comments from a wide range of interested parties. The Department of Health, therefore, decided to establish a working party which was to advise it on the implementation of the recommendations contained in the report. This working party comprised members of the Department of Health, the Cancer Society and the Ministry of Women's Affairs and it consulted widely with interested individuals and met from November 1986 to early 1990.

From 1986 the Ministry of Women's Affairs maintained a close working relationship with the Department of Health in the establishment of a NCSP. At their instigation, (Ministry of Women's Affairs 1987) four pilot cervical screening programmes were established around the country to determine the best ways to reach unscreened low-income and Maori women.

2.4 The Metro article

In June 1987, an article appeared in Metro magazine which would have far reaching consequences for health policy in New Zealand. The Metro article written by Sandra Coney, a freelance journalist, and Phillida Bunkle, an academic, described controversial experimental research at National Women's Hospital in Auckland which had been initiated in

the 1960s. This controversial research included the experimental treatment of women who had abnormal cervical cells, without their knowledge or consent (Coney & Bunkle 1987).

The controversial research at National Women's Hospital in Auckland was conducted by Doctor Herbert Green, Associate Professor in the Department of Obstetrics and Gynaecology. He hypothesised that "carcinoma in-situ (abnormal cells which are generally deemed to be the pre-cursors of cancer) is not a pre-malignant disease" (Cartwright 1988 pg 21). He therefore proposed, in 1966, that a certain number of women with cervical carcinoma in situ should be treated by lesser procedures than previously. This proposed treatment consisted of close observation only, without the performance of any prophylactic or precautionary interventions i.e. minor surgery, cautery etc. He was out to prove both that carcinoma in situ was not a pre-malignant disease and that less invasive treatments were desirable and appropriate.

Green observed a number of women with cervical carcinoma in situ over a number of years in the belief that they did not require treatment because the cervical abnormality would not progress to cancer. This belief was in direct opposition to the views of most experts in Europe, the United States of America and Australia (Cartwright 1988).

The most controversial aspect of Green's research was that he did not inform the women involved that they were experimental subjects. The women, therefore, did not know that they had abnormal smears which could have potentially serious consequences. The experimental research was thus unethical because the women concerned were not informed about their conditions or their participation in experimental research (Cartwright 1988).

On 10 June 1987, the Minister of Health, Michael Bassett, appointed a *Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters*. Judge Silvia Cartwright was appointed to head the Inquiry and directed to report back to the Minister by the 31 August 1987. Judge Cartwright was to enquire into the treatment of cervical cancer at National Women's Hospital, Auckland.

2.5 The Cartwright Report and the Government's response

The Report of the Cervical Cancer Inquiry (Cervical Cancer Report) was published in July 1988. Among several recommendations that were made by Judge Cartwright was one suggesting that: "A nationally planned population-based screening programme should be implemented urgently" (Cartwright 1988:216). The publication of the Cervical Cancer Report presented a serious challenge to the Green school of thought, that carcinoma in situ does not progress to cervical cancer.

The Government's response to the publication of the Cartwright Report was swift. David Caygill who succeeded Michael Bassett as Minister of Health promised that the recommendations made by Cartwright would be fully implemented (Minister of Health 5 August 1988). The Government's public declaration of substantive policy relating to the NCSP placed the Department of Health in the position of having to develop procedural policy for the programme.

In 1988 cervical cancer was not thought to be a major health problem in New Zealand in terms of the mortality rate (Department of Health 1987). At that time, each year about 200 New Zealand women were diagnosed as having cervical cancer and another 100 women died of it (Skegg et al 1985). The cervical mortality rate of about 100

contrasted with about 600 in breast cancer, for example (Department of Health 1987).

An important feature of successful cervical screening programmes overseas was the utilisation of computerised registers as fundamental management tools for the collation of screening data (Hakama 1985; Ebeling & Nischan 1986; Mitchell & Medley 1987; Lynge, Madsen & Engholm 1989; Miller, Anderson, Brisson, Laidlaw, Le Pitre, Malcolmson, Mirwaldt, Stuart & Sullivan 1991). The World Health Organisation (1986) had identified computerised registers to manage the cervical smear data as important criteria for successful cervical screening programmes. The use of computerised registers for the organisation of cervical screening data in New Zealand had been consistently advocated by the experts (Skegg et al 1985; Straton 1990).

In September 1988, the Department of Health commissioned a report from Azimuth Systems Ltd, an information technology (computer) consultancy firm, about the requirements for the development of computer registers for the NCSP. This report was submitted to the Department later that same year (Seaman & Van der Tol 1988). In early 1989 the Department commissioned Azimuth to develop the software for the computerised registers for the NCSP and to provide advice when requested.

Cartwright (1988) had recommended that a wide range of women and consumer groups should be consulted about the needs of women in such a screening programme. The Department of Health, therefore, convened a national cervical screening workshop at Porirua (Porirua Workshop), in December 1988. The Minister of Health, David Caygill, gave the opening address and indicated that the role of the workshop participants was to recommend to the government how best to structure a national programme (Department of Health 1991).

Approximately one hundred people who were broadly representative of groups and organisations which were closely involved with the provision and consumption of cervical screening services attended the workshop. There were three days of activity and debate culminating in the formulation of several recommendations which were sent to the Minister of Health (Department of Health 1991).

One recommendation of this workshop was that an executive group be established which had decision-making power to control and allocate funding for a NCSP (Department of Health 1991). This recommendation mirrored that made by Cartwright that "The Minister of Health should establish a group representative of a wide range of women health consumers and appropriate health professionals, including representatives of cytology, pathology, colposcopy and nursing personnel" (Cartwright 1988:209).

Helen Clark succeeded David Caygill as Minister of Health in January 1989 and by April 1989 was questioning the Department of Health about the lack of progress on the development of the NCSP and stating her dissatisfaction with policy advice which the Department had sent to her (Minister of Health 10 April 1989).

In June 1989, the Minister of Health, Helen Clark wrote to the Director-General of Health requesting costings advice from the Department so that an announcement relating to the NCSP could be made in the Budget (Department of Health 14 July 1989). In June 1989, the Wanganui and Marlborough Area Health Boards were selected to pilot the computerised register which had been developed by Azimuth. These pilots became operational in September 1989.

In July 1989, the Minister of Finance, David Caygill presented his Budget. The NCSP was allocated \$37.6 million dollars over the following three years (\$14 million for

year one and \$11.8 million for the subsequent two years) (Minister of Finance July 1989).

On 25 August 1989, the Minister of Health, Helen Clark, wrote to the Director-General of Health again expressing concern about the direction that the Department was taking in relation to the NCSP (Minister of Health 25 August 1989). She noted that there was widespread concern from groups such as the Cancer Society about the Department's preoccupation with the development of the computerised register to the exclusion of a comprehensive policy framework (Minister of Health 25 August 1989). Her intention was to require the Department to establish a review team to monitor and report on the Department's progress to date (Minister of Health 25 August 1989).

On 31 August 1989, the Minister wrote again to the Director-General of Health about the progress of the NCSP. She expressed dissatisfaction with the Department's handling of the proposed review of progress to date and informed the Director-General of Health that she proposed to establish a formal Ministerial review of the NCSP (Minister of Health 31 August 1989).

In December 1989 the Minister of Health produced the document, *A New Relationship: Introducing The New Interface Between The Government and The Public Health Sector* (Minister of Health 1989). This document, often referred to as the "Goals and Targets", identified the Labour Government's public health policy priorities which included cervical cancer policies.

2.6 The Ministerial Review Committee

A Ministerial Review Committee was established in September 1989 to review progress on the establishment of the NCSP

and advise the Minister on future directions. Membership of the committee was as follows:

Sandra Coney	Fertility Action, Auckland Women's Health Council, other consumer groups
David Crook	Royal College of General Practitioners
Brian Cox	Department of Social and Preventive Medicine, Otago
Gillian Durham	Project Leader, National Cervical Screening Implementation Unit
Maree Leonard	Programme Co-ordinator, Marlborough Area Health Board
Betsy Marshall	Cancer Society
Robin McKinlay	Ministry of Women's Affairs
Neil Prentice	New Zealand Medical Association
Heather Simpson	Chairperson
Clint Teague	Cytopathologist, Wellington
Wairete Walters	Maori Women's Welfare League.

The Review Committee met three times and considered a wide range of issues involved in the establishment of a NCSP. The Committee did not provide detailed and comprehensive recommendations, preferring to confine itself to the provision of general recommendations on the general direction which the programme should take and the procedures which should be followed to ensure the programme met its objectives (Report of The Ministerial Committee on Implementation of a National Cervical Screening Programme 1989). *The Report of The Ministerial Review Committee on Implementation of a National Cervical Screening Programme* was produced in November 1989.

Among several other recommendations the Ministerial Committee recommended the establishment of an Expert Group to oversee and monitor the implementation of the NCSP (Report of The Ministerial Review Committee on Implementation of a National Cervical Screening Programme 1989). This Expert Group was to consist of representatives

of medical, nursing, policy and various consumer groups. This recommendation was similar to that made both by Cartwright and the Porirua Workshop in 1988 (Cartwright 1988; Department of Health 1991).

2.7 The Expert Group

The Expert Group was established by December 1989, and was to provide advice to the Minister on the implementation of the NCSP.

On 18 December 1989 the Expert Group, funded and serviced by the Department of Health, held its first meeting in Wellington. This first meeting was chaired by an official from the Minister's office. Membership and representation of the Group was as follows.

Dr Robin MacKinlay	Ministry of Women's Affairs
Wairete Walters	Maori Women's Welfare League
Linda Erihe	Te Korimako Mauriora Centre
Doreen Arapai	Pacific Islands women
Sandra Coney	Consumers, Fertility Action
Corinne Stevenson	The Health Alternatives For Women
Dr Peter Moodie	General practitioners
Dr Howard Clentworth	Obstetricians and gynaecologists
Joy Bickley	New Zealand Nurses Association
Dr Clint Teague	Laboratory Cytopathologists
Dr Ruth Bonita	Community Health and General Practice
Dr Christine Roke	Family Planning Association
Betsy Marshall	The Cancer Society.

A chair for the Expert Group was a priority for the Minister's office and Dr Peggy Koopman-Boyden accepted her nomination on 7 February 1990.

The Expert Group held twelve meetings altogether between December 1989 and February 1991. The dates of the meetings are contained in Appendix I.

The initial task undertaken by the group was to break itself up into smaller sub-committees. There were six sub-committees altogether and they were identified as follows:

1. Education, Communication and Acceptability Sub-committee
2. Register Issues Sub-committee
3. Training and Monitoring of Smear-takers Sub-committee
4. Policy of the National Cervical Screening Programme Sub-committee
5. Pacific Island Women Sub-committee and
6. Performance Indicators and Evaluation Sub-committee.

The general aim of the group was to develop policy on: promotion of cervical screening; the register; training and standards of competency for smear-takers; development of a women-centred service and performance standards for evaluation of the programme. The group then sought the information on which to base policy decisions.

The Expert Group utilised various documents which were commissioned by them and then available within the Department of Health. The Expert Group advised the Department to commission: an analysis of the literature relating to screening in New Zealand (Paul 1990); a National Research Bureau (NRB) Poll on levels of cervical screening in New Zealand (NRB 1990) and a review of the literature relating to cervical screening programmes both in New Zealand and overseas (Adams 1991). These documents formed the basis for the development of the Expert Group's Policy Statement (National Cervical Screening Programme: Policy Statement of the National Cervical Screening Programme Expert Group) which was a comprehensive policy

framework for the NCSP (Appendix II). As well as the Policy Statement the Expert Group produced policy guidelines and standards of competency for smear-takers. These policies formed the basis for the NCSP which was in the process of being established within the fourteen area health boards.

The Expert Group advised the Department of Health to invite an eminent cervical screening expert, Dr Judith Straton of Australia, to New Zealand to review current and proposed cervical screening practices. Dr Straton visited five cervical screening pilot sites around the country. In addition she met with cervical screening experts in New Zealand and addressed the Expert Group at the culmination of her visit. The report on this review was received by the Department in July 1990 (Straton 1990).

The Expert Group's Policy Statement was produced in August 1990 (National Cervical Screening Programme: Policy Statement of the National Cervical Screening Programme Expert Group). This statement was the culmination of a great deal of analysis, research and wide consultation (Appendix II).

2.8 Summary

This chapter focused on the historical events which preceded and influenced the decision to adopt as substantive policy the development of a NCSP. The origins of the NCSP can be found as far back as the 1960s when trials were conducted on the efficacy of population-wide cervical screening services. There was not enough political interest, in those early days, in programmes such as the NCSP. Cervical cancer in New Zealand had lower morbidity and mortality rates relative to such health problems as breast cancer and was thus of a lower policy priority.

It wasn't until June 1987 when Sandra Coney and Phillida Bunkle wrote their expose about the controversial experimental research at National Women's Hospital in Auckland that cervical cancer gained political prominence. The experimental research was conducted by Professor Green of National Women's Hospital who was of the opinion that cervical carcinoma in situ did not necessarily progress to invasive cancer of the cervix. He, therefore, observed women with cervical carcinoma in situ over a number of years without treating them. Professor Green's non-treatment of these women was controversial for two reasons. Firstly, Professor Green's medical opinions were not shared by other national and international experts in this area who advocated early treatment of cervical abnormalities so as to prevent cervical cancer. Secondly, Professor Green did not inform these women that they were the subject of research.

The media took an interest in the events at National Women's Hospital. After the publication of the Metro article the Government ordered a Royal Commission of Inquiry into the events at National Women's Hospital, the outcome of which was the recommendation to establish a NCSP.

The Government publicly stated its commitment to carry out the Royal Commission's recommendations and thus a substantive policy decision had been made. The Department of Health then had the task of developing the strategies needed for the establishment of a NCSP. The Minister of Health was of the opinion that the Department of Health was making slow progress so she appointed a Review Committee to advise her on the requirements for the establishment of the NCSP. This Review Committee recommended the establishment of an advisory committee, the Expert Group, to provide the Minister with advice about the implementation of the NCSP.

The Expert Group was formed and comprised professionals and consumers. Their role was the development of policy for the NCSP. In order to acquire the information on which to base policy they advised the commissioning of considerable research which formed the foundation for their Policy Statement of August 1990.

The Expert Group developed the policy for the NCSP and therefore comprised the bulk of the key informants in the present case study. Many of them were interviewed and their opinions sought about issues relating to their policy-making experiences. The next chapter provides information about the research methodology employed in this case study noting the constraints and positive aspects.

CHAPTER THREE

RESEARCH METHODS AND PROCEDURES

3.1 Introduction

This chapter focuses on the research methodology used in the present study of the NCSP which is particularly focussed on the process of policy development. It describes the research methods used, including a search of the literature relating to policy analysis and cervical screening and perusal of relevant documents held within the Department of Health. In addition to the scrutiny of relevant working documents, interviews were held with some of the individuals who were closely involved with the development of the NCSP policy. To guide and focus the research a modified version of Leichter's framework was utilised. This framework formed the basis of the questions put to interviewees and was modified during the research process.

The researcher is the National Co-ordinator of the NCSP and was appointed to this position on 5 June 1990. She was, therefore, closely involved with the development and implementation of the NCSP policy from that time and brought a personal perspective to the present case study of the NCSP policy.

3.2 Research aims and methods

This thesis is a case study of the NCSP policy and an analysis of the process of policy development. The aim was to attempt to identify the major influences on the development of the NCSP policy. A further aim was to study consumer participation in the process of the development of

the NCSP policy. Of particular interest was the representativeness of consumer participants and the perceived degree of influence they had relative to the professional bureaucrats in the development of the NCSP policy.

The methodology employed in the present research was the case study method including a literature search and interviews with key informants in the policy-making process.

3.3 The Case Study

According to Dixon, Bouma and Atkinson (1987: 107) "In a case study, a single case (hence the name) is studied for a period of time" with the aim of description. In this present case study the case under study was the NCSP policy and the process of its development. The process of the NCSP policy development and consumer participation in this process was the focus of interest. To guide the research the framework devised by Leichter (1979) was used¹. This framework was chosen because it appeared comprehensive in its coverage of factors which influence the development of policy. It also appeared to be organised, logical and useful in focusing the research.

Leichter (1979) devised a framework for policy analysis which included four policy-impacting factors:

- (1) Situational factors - transient, impermanent and idiosyncratic events;
- (2) Structural factors - relatively unchanging elements of a society, the more permanent and persistent features of a system;
- (3) Cultural/ideological factors - the values, assumptions and social theories underpinning the policy process and

¹ Leichter's framework was introduced in Chapter One page 5.

(4) Environmental factors - events, structures and values that exist outside the boundaries of a political system but that influence decisions within a system.

In the present case study the situational, structural, cultural/ideological, environmental and personal factors were studied together with the factors associated with the process of consumer participation in the development of the NCSP policy.

The case study method was chosen because the goal of the research was a description of the NCSP policy development process and it is the commonest research method used in studies of the policy process (Hill & Bramley 1986). Information, in a case study, can be obtained via a review of documentary records and interviews with key informants (Hill & Bramley 1986). A review of documentary records and interviews with key informants were methods used in the present study of the development of the NCSP policy.

3.4 Literature search

A search was made of selective relevant documents held within the Department of Health. These documents included memoranda to the Minister of Health from various departmental officers, Ministerial memoranda to the Director-General of Health, internal memoranda between the Director-General of Health and the Cartwright Projects unit within the Department, the minutes of all Expert Group meetings and other departmental "cervical screening" files which appeared appropriate. A library search was made of books and journals related to social policy analysis and related topics. A library search was also made of "cervical screening" articles which appeared in various newspapers, journals and magazines.

3.5 Interviews

Interviews were conducted with a purposive sample of key informants i.e. interviewees were selected by the researcher based on their involvement with the development of policy for the NCSP. According to Dixon et al (1987: 139) purposive sampling is utilised by some researchers who "believe that they can, using their own judgement or intuition, select the best people or groups to be studied." Purposive sampling is usefully employed when there are key informants who have the knowledge or experiences under study (Burgess 1984). Interviews are ethnographic research methods useful in the study of the social and cultural patterns of groups of people (Sanders 1974).

All thirteen members of the Expert Group were approached to participate in the research. Five Expert Group members were consumer representatives and eight were professional representatives. Two key public servants and one of the three Ministers of Health (during the development of the NCSP policy) were approached to participate. The Expert Group members were selected because they developed the first policy statement for the NCSP. The public servants and the politician were selected because they had pivotal roles in the development of the NCSP policy. Both public servants held senior positions within the Department of Health.

All interviewees were sent a letter broadly outlining the researcher's intention to study the NCSP policy and requesting their participation in interviews (Appendix III). The letter stated that a questionnaire would follow the interviews. The plan to develop a questionnaire was abandoned after the interviews as it no longer appeared to be feasible within the projected time frame. In the letter a commitment was given to the protection of individual identity.

Twelve of thirteen Expert Group members agreed to participate in the research and one refused. The Expert Group member who refused to be interviewed was a consumer representative. Of the twelve members who agreed to participate two were not interviewed because they were not available at mutually convenient times. Several attempts were made to connect with these two Expert Group members without success. In the interests of completing the research no further attempts to interview those two Expert Group members were made. One of these Expert Group members was a consumer representative and the other was a professional representative. The two public servants and the Minister of Health agreed to be interviewed. A second letter was sent to the interviewees who had agreed to be interviewed. A consent form for interviewees (Appendix III) and the schedule of interview questions was included with this letter.

All interviewees were assured that their identities would be protected. For this reason and because all the individuals involved would be potentially readily identifiable interviewees were divided into three groups. The "Expert Group" members were divided into two sub-groups, "consumers" and "professionals" while the public servants and Minister were identified as the "Bureaucrats-Politician" group.

A schedule of interview questions was developed based on the framework developed by Leichter (1979). The schedule of interview questions (Appendix IV) was closely followed during eleven of the interviews. At the completion of the eleventh interview it was clear that there was a significant degree of consistency in the answers to many of the scheduled questions. For the final two interviews, therefore, some scheduled questions were omitted and questions focused more closely on the interviewees' personal involvement and consumer participation in the policy-making process.

Final arrangements were made for the interviews once letters were received from potential interviewees agreeing to participate in the research. All interviews, except one were electronically recorded and then transcribed. The researcher transcribed all recorded interviews except two. These two exceptions were transcribed by a personal friend. The tape recorder did not function at the interview that was not electronically recorded. Notes were taken during this interview which were then written up. Interviews were recorded because this would provide a potentially accurate account of the interview experience which could be analysed on an on-going basis and would also serve as a memory aid (Schatzman & Strauss 1973).

All transcripts were sent to the interviewees who were able to alter, add or delete any of their written material (Appendix III). The altered transcripts were then returned to the researcher for analysis. All interviewees, except the politician, had some previous professional contact with the researcher as National Co-ordinator of the NCSP.

The first interview was arranged for May 1991, in Wellington, with a member of the Expert Group. Leichter's (1979) framework was trialled during this interview. At the completion of the interview the researcher was dissatisfied with the lack of breadth of the information gained from the interviewee and attributed this to the constraining nature of Leichter's framework. Therefore, a further section entitled "More Personal Factors" was added to Leichter's framework. The expanded framework was trialled at the second interview and appeared satisfactory in terms of the breadth of information elicited.

All interviews, except one, were held in either the homes or offices of interviewees. Thus interviews were held in Wellington, Auckland and Christchurch. One public servant was interviewed in a meeting room in the Department of

Health, Wellington. Interviews lasted from one to two and a half hours.

3.6 Problems encountered

There were problems encountered in the research, one of which related to the constraining nature of Leichter's framework which did not allow for any personal input from policy-makers. The framework was, therefore, altered to include a more personal perspective.

As the researcher was closely involved both with the policy-makers for a time and with the implementation of the NCSP policy the research findings may reflect a personal perspective which needs to be borne in mind. That is not to say that the research findings are any less valid.

A further problem attributable to the researcher's personal participation in the NCSP was the inability of some interviewees to perceive the researcher in a research role rather than in her role as the National Co-ordinator. For example when one interviewed consumer representative Expert Group member was asked who made the final policy decisions she said "I think we gave that back to you in some instances." This perception may well have influenced the findings. Interviewees, for example, may not have felt able to be as frank as they might have been had the researcher been less closely involved with the NCSP.

The examination of the relevant working documents within the Department of Health proved to be relatively uninformative. For example, the minutes of the Expert Group meetings contained little useful information. There were many issues, events and personal interests which were reported during the interviews but these were not evident or recorded on the official documents.

A major debate such as the appointment of Maori regional co-ordinators was not recorded within the Expert Group minutes in enough detail to enable an appreciation of all the reasons for the discussion. During the interviews it became more evident that the issue of Maori regional co-ordinators was used for reasons other than those recorded in the records. One interviewed professional Expert Group member made the following observation "The Maori thing came up...prepared to give time to that.....forced to give time to that. In the interests of the decision and the group process...it was useful." In other words the debate surrounding this issue was useful in the furtherance of group cohesion and rapport.

The utilisation of debate for the development of group cohesion rather than for the determination of a policy decision was not reflected in the official documents. The official documents focussed on the content of the debate. During an interview with a key informant it became evident that the debate had been useful for the development of group cohesion as well as the formation of a policy decision. So any policy analysis which relied solely on an examination of the working documents could well glean only one small part of a complex picture related to policy development.

Some of the frustrations associated with this research related to the unreliability of technical equipment such as the failure of electronic recorders, the extensive travelling involved and the repetitiveness of the answers to some of the questions. The transcription of recorded interviews is an onerous task but an interview can be usefully analysed several times as it is difficult to glean all the relevant information after one hearing only. This repeated analysis of interview data is time-consuming.

3.7 Summary

This case study involved a search of the relevant literature surrounding the development of the NCSP policy and social policy development in general, focussing particularly on the participation of consumers in the policy-making process. The methods used in this case study were literature searches and interviews with key informants about the NCSP policy-making process using Leichter's framework as a guide.

Some of the problems encountered in this research related to technical procedural issues such as breakdown of electrical equipment and the difficulties of being a researcher when closely involved with the implementation of a policy. A more serious problem which has implications for future research in the area of policy analysis is the blandness of official documents; any research which relied solely on document analysis to provide information about the processes of policy development might not result in a comprehensive picture of this complex process.

The following six chapters provide the reader with the results of the research which are discussed in relation to the situational, structural, cultural/ideological, environmental and personal factors including consumer participation in policy development.

A discussion of the findings related to this research begins in the next chapter with an elaboration of the situational factors, those transient and relatively idiosyncratic factors, which interviewees maintained influenced the development of the NCSP policy.

CHAPTER FOUR

THE SITUATIONAL FACTORS AFFECTING THE NCSP POLICY

4.1 Introduction

This chapter presents the research findings in relation to the situational factors which appeared to have a significant influence on the development of the NCSP policy. Situational factors refer to the extraordinary, impermanent or idiosyncratic events, occasions, individuals and groups which exist within a political and social system.

The chapter begins with a description of the significant New Zealand events which interviewees maintained had an influence on the development of the NCSP policy. The single most significant event to influence the NCSP policy was the Cartwright Inquiry, according to interviewees. The groundwork for population based cervical screening had been laid before the Cartwright Inquiry by other events.

As well as significant events, there were significant or dominant individuals who influenced the development of the NCSP policy. Several individuals who were influential in the development of the NCSP policy were affiliated with groups or organisations which also exerted an influence to foster the development of the NCSP policy. While there were groups which supported the NCSP policy, there were other groups which did not appear to do so.

During the development of the NCSP policy there were significant phases/stages according to the interviewees. These phases/stages are described in this chapter.

In order to preserve as much as possible the anonymity of interviewees, no individual interviewee is identified, even with a pseudonym. All interviewees are divided into three groups: the Expert Group-Consumer (EG-C) group; the Expert Group-Professional (EG-P) group and the Bureaucrats-Politician (B-P) group. Thus all quotations from interviewees used in this thesis are identified as (EG-C), (EG-P) or (B-P) to signify the group to which the interviewee belonged. These identifiers are used throughout the rest of the thesis.

4.2 The significant New Zealand events which influenced the policy

According to the interviewees the significant events which influenced the development of the NCSP policy were: the publication of the Skegg recommendations in 1985; the meeting of the Cancer Society and the Department of Health in 1986; the restructuring of the Department of Health; and the Cartwright Inquiry in 1988¹. The research showed that the Cartwright Inquiry was the most significant event to influence the development of the NCSP policy. As one interviewee stated "Although there had been discussions about having a cervical screening programme as early as 1985 I think without a doubt it was the Cartwright Inquiry which influenced the development of the policy." (EG-P). *The Report of the Cervical Cancer Inquiry* was released in August 1988 followed closely by a public statement of commitment by the Labour Government to implement Cartwright's recommendations (Minister of Health August 1988). This public pledge by the Government ensured strong political support, particularly for the establishment of a NCSP.

The Department of Health had no opportunity to evaluate Cartwright's recommendations and provide the Minister of

¹ These events are described in more detail in Chapter Two.

Health with advice. As one interviewee stated "I would have said to David Caygill, 'Please don't say yes to everything immediately. Can we talk about it?'" (B-P). When asked whether the Minister of Health consulted with the Department of Health about the Cartwright recommendation to establish a NCSP one interviewee stated "No. They were so keen to show themselves co-operative with the Cartwright recommendations that they accepted them immediately. It's not sensible to do that. They were just so wanting to please. Normally we don't do it like this. We let people know that we are considering it and then look at all the implications. They just jumped in." (B-P).

The Department of Health had been evaluating the need for a NCSP since the 1985 meeting with the Cancer Society but cervical cancer was not a priority health problem at that time. The Minister of Health, Helen Clark, assumed the responsibility for determining the health priorities for New Zealand's health policies in 1990. It was her office which produced the "New Zealand Health Goals and Targets" which were presented to the Department of Health (Minister of Health: December 1989). The health priorities identified by the Minister of Health related to: tobacco smoking, nutrition, alcohol misuse, high blood pressure, motor vehicle crashes, hearing loss, asthma, coronary heart disease and stroke, cervical cancer and skin cancer. The decision to define cervical cancer as a priority health issue requiring the development of policy was thus determined by the Minister of Health, Helen Clark.

So the policy for the NCSP was politically determined without consultation with the Department of Health. This policy was thus imposed on the bureaucrats and may explain why the policy was slow to be implemented. An imposed policy leaves little discretion for bureaucrats in the policy-making process. Fox (1974) examined the notion of discretion as it applied to industrial relations and found

that a top-down approach tended to relate to low-trust situations which in turn led to a lack of commitment.

Restructuring of the Department of Health had been on-going since 1986 and was particularly extensive between January and October 1989. The re-structuring and subsequent changes in personnel could have contributed to a lack of continuity in the oversight of the NCSP policy. The constant reorganisation of the Department was identified as a serious disruption to its smooth operation. As one interviewee commented "In the meantime the Department is going through a constant reorganisation. So there were a lot of events which took place in a particularly turbulent time, politically, organisationally and administratively. All of that had an effect..." (B-P). Another interviewee commented "I just think it was too big for the Health Department. It was constantly being restructured." (B-P).

There were several changes of Departmental personnel who had been responsible for the NCSP policy. Initially Dr Karen Poutasi was responsible for the NCSP until 1988. Dr Gillian Durham then assumed responsibility for the NCSP until late 1989. At that time Ms Sandra Davies assumed responsibility for the NCSP until April 1991. The changes did not allow for consistency or enable strategic planning. Thus the development of the NCSP policy was subject to the disruptions associated with lack of continuity of personnel leading to inconsistencies during the early stages of policy development.

The meeting of the Cancer Society and the Department of Health in 1986 was identified as a significant event in the development of the NCSP policy. One interviewee commented "There was the meeting with the Cancer Society in 1986." (EG-C).

The publication of the Skegg recommendations in 1985 was another significant event identified by some interviewees.

One interviewee stated "Undoubtedly it goes back to David Skegg's published recommendations that predated the Cartwright Report." (EG-P). Another interviewee remarked "It (interest in cervical screening) did not have its origins in the Cervical Cancer Inquiry. Skegg and others had already begun to talk about the value of a cervical screening programme for New Zealand." (B-P).

Thus the most significant event which influenced the development of the NCSP policy was the Cartwright Inquiry. Other significant events were: the publication of the Skegg recommendations and a meeting involving the Cancer Society, the Department of Health and Skegg. These other events involved individuals and organisations which had an interest in cervical cancer. The individuals who were influential in the development of the NCSP policy are discussed in the next section.

4.3 Dominant individuals who influenced the policy

There were some dominant individuals who influenced the development of the NCSP policy, according to the interviewees. This research indicated that these individuals were perceived as making significant contributions to the development of the NCSP policy. The individuals identified as being particularly influential included members of the medical profession as a whole and particularly Drs Grey, Skegg and Paul, Sandra Coney, the Minister of Health Helen Clark, Ruth Bonita and Peggy Koopman-Boyden.

The influential members of the medical profession had worked for many years to promote cervical screening on a national level as a desirable health policy. Dr Alan Grey of the Cancer Society of New Zealand and Dr David Skegg and Dr Charlotte Paul of the Department of Social and Preventive Medicine at Otago University were identified as being particularly prominent. As one interviewee commented

".. Alan Grey and Co, Skegg and Paul, Coney and Bunkle and Bonita. They were all powerful personalities." (B-P).

A prominent individual identified was Sandra Coney who co-authored the Metro magazine article in June 1987 which sparked the inquiry into the proceedings at National Women's Hospital in Auckland. She attended the Porirua Workshop in December 1988, was a member of the Ministerial Review Committee of September 1989 and sat on the Expert Group as a consumer representative. One interviewee commented "Yes personality definitely affects and dictates policy development. Sandra Coney..." (B-P).

Helen Clark was identified as a significant personality in the development of this policy. The general opinion was that it was because she was Minister of Health in 1989 that the NCSP was given strong support. Doubts were expressed by some interviewees about whether the NCSP policy would have been developed if she had not been Minister of Health. As one interviewee stated "In terms of leadership it was Helen Clark who provided the direction and seemed to be behind the scheme." (EG-P). Another interviewee commented "I think Helen Clark was really committed to it and committed to it in the face of the direction and flow of policy in the whole health sector because a national programme was running counter to the devolution of responsibility to area health boards." (EG-P).

Ruth Bonita was identified as an influential personality in the development of this policy. Ruth was a friend of both Helen Clark and Sandra Coney. One interviewee stated "Behind the scenes one can't underestimate the importance of people like Sandra Coney and Ruth Bonita. I think their influence was important." (B-P).

Peggy Koopman-Boyden, chair of the Expert Group, fulfilled a leadership role in the development of this policy. A major problem in the development of this policy was the

lack of an identified leader who "owned" and worked towards the establishment of the NCSP. As one interviewee stated "That was the problem, there were few leaders. The DG wasn't a leader. The Minister wasn't a leader. The Department of Health wasn't a leader. That was part of the reason for the problems." (EG-P). Peggy was described as being supportive of the consumer voice and ensuring that policy development occurred in a timely fashion. One interviewee commented "Peggy was really important in supporting that consumer perspective but also supporting it because she's a social scientist." (EG-C). Another interviewee stated "Type of chairing influenced the dynamic of the group. Peggy ran a tight ship." (EG-P). Interviewees were in no doubt that the chair performed a difficult function well. An interviewee commented, "Expertise brought by the chair was not related to screening but she rapidly picked up that expertise. Chaired a difficult group very ably." (EG-P).

All the above individuals were reported as making significant contributions to the development of the policy. Some of these prominent individuals were members of interest or pressure groups that had had involvement with cervical screening over a number of years. The Cancer Society (Dr Alan Grey) and the Department of Preventive and Social Medicine, Otago (Drs Skegg and Paul) were involved with the Cartwright Inquiry. Sandra Coney and Ruth Bonita were members of women's health groups in Auckland. These individuals could be described as the elite in terms of policy-makers.

Hill (1982) has described influential non-bureaucratic policy-makers as those individuals from pressure groups who gain entry into powerful decision-making groups by virtue of their expertise, persistence and charm. These individuals then abide by the norms associated with group participation in policy-making groups and thus get nominated over and over again to sit on advisory committees

(Hill 1982). All of these influential individuals, except Peggy Koopman-Boyden, have had a long association with cervical screening in New Zealand and all could be described as having a powerful influence (Hill & Bramley 1986) over the development of the NCSP policy.

4.4 Dominant groups and organisations

Interest groups which have strong views about a particular policy are known to strongly influence bureaucrats and politicians (Hill 1982). The interviewees identified groups which influenced the development of the cervical screening policy.

The Cancer Society of New Zealand, the Department of Social and Preventive Medicine in Otago and women's groups were identified as strong supporters of the policy. One interviewee maintained "The Cancer Society which has steadfastly tried to ensure that there was a screening programme." (EG-C). A further interviewee commented "Skegg and the Department of Medicine (were strong supporters)." (EG-P). Women's groups, particularly the Auckland Women's Health Council and Fertility Action were all active in their strong support of the NCSP policy, according to interviewees. One interviewee stated "Women and women's groups." (B-P). Another interviewee commented "I was conscious of the women's health organisations and their representatives like Sandra and Ruth and the Auckland women as well. I'd name Auckland Women's Health Council." (B-P).

The Auckland women's groups were closely linked to each other and to particular individuals. Sandra Coney, Ruth Bonita and Betsy Marshall appeared to have close ties with women's groups, Helen Clark and each other and were members of the Expert Group. James (1991), in a discussion about business pressure groups and their attempts to influence ministers, found that all lobbyists required rigorous logic

to be successful. The close association that some of these women appeared to have with Helen Clark was not a sufficient explanation for any influence they may have exerted in favour of the policy. There were sound and scientific bases for the policy arguments that they put forward². These women held dominant decision-making roles in the Expert Group and could be described as an elite group.

While the above interest groups supported the NCSP policy, there were other groups which interviewees stated appeared indifferent to or antagonistic towards the development of the policy. The groups identified as being non-supportive were the medical profession, the Department of Health and senior administrators within the Department of Health and the area health boards. One group which appeared to have a low profile was the medical profession. The medical profession's perceived lack of enthusiasm for the cervical screening policy led some interviewees to the opinion that the profession did not support the policy. As one interviewee stated "I think there were all sorts of groups that were against it. For example you had the medical profession which wasn't prepared to admit that there was anything wrong with what they were already doing. I think that the medical profession's attitude to the programme was rather shabby." (B-P). Another interviewee maintained "I suppose some of the general practitioners were (against the NCSP policy). I don't know if it was more passive than active. From time to time there were issues raised about the efficacy of screening. Probably generally, the practitioners were feeling that they were dealing with it pretty efficiently." (B-P).

The medical profession might have had reservations about some proposed aspects of the policy which could have led

² *The National Cervical Screening Programme: Policy Statement of The National Cervical Screening Programme Expert Group* (August 1990) cites many authoritative sources which underpinned the policy.

the profession to question the validity and future success of the implemented policy. Thus the medical profession could have been reluctant to be associated with a policy that it perceived was doomed to fail. As one interviewee commented "I don't think there was anyone against it as such. There are people who are concerned that it's not going to work. The medical profession would be in that camp." (EG-P). A further reason for the medical profession's apparent lack of support for this policy could have been embarrassment in the aftermath of the Cartwright Report. One interviewee stated "Post-Cartwright there was a certain surliness about the medical profession, a feeling of being hurt." (B-P).

The majority of interviewees were of the opinion that the Department of Health did not support the NCSP policy development. One interviewee stated "The senior members of the Department are scared and they don't want to be saddled with this programme." (EG-P). Another interviewee commented "... it was not really something that the Department wanted to do." (B-P). Another interviewee commented "It was going the wrong way in terms of the Department, that is centralising instead of regionalising." (EG-P). Another interviewee maintained "At the time the policy was finished, we had the support of the Minister. We didn't have the support of the hierarchy in the Health Department." (EG-C). Another interviewee remarked "There was a predisposition not to have a central framework for the programme and not to keep a close eye on it. There was a belief that we should really leave it to the boards to get on with it, that the money shouldn't even be tagged. No I don't think it had their (the Department's) support at all." (B-P).

There had, in the Department's opinion, been no evaluation of the need for a NCSP. This view is supported by the research findings which demonstrated that the NCSP policy had not been developed by the traditional technocratic

process. An interviewee stated "There were no options. We were given the solution and had to work backwards. The Department was in a no-win situation. We were given a solution to a problem rather than being given the various problems and then given the opportunity to consider various alternatives for a solution." (B-P).

Some interviewees stated that the senior administrators within the area health boards did not appear to fully embrace this policy. The support of administrators within area health boards was thought to be crucial to successful implementation of the NCSP policy. Interviewees were uncertain of area health board support for this policy. As one interviewee stated "Obstruction came at the senior management level. I suspect that senior area health board personnel would feel the same but can't really comment." (EG-P). Another interviewee commented "I have some concerns about whether there is support for this from area health boards." (EG-P). Another interviewee remarked "Mixed support from area health boards." (EG-P). One interviewee summarised the situation as "There was covert obstruction from all levels everywhere; within the Department of Health, area health boards and general practice." (B-P). So administrators as a group were viewed by interviewees as being non-supportive of the policy.

4.5 The significant phases/stages in the policy-making process

According to the interviewees the significant phases/stages in the policy-making process were: the ministerial review of 1989; the Expert Group's recognition that policy development was needed; the collection of baseline data and Dr Straton's visit to New Zealand in 1990. According to interviewees the most significant stage initially was the September 1989 ministerial review of the Department of Health's implementation of Cartwright's recommendation to

establish a NCSP. This Review Committee supported the implementation of Cartwright's recommendation to establish an Expert Group to provide advice on implementation of the NCSP. The Review Committee wrote "Concerns were expressed by the Review Committee thatno committee such as that described by Judge Cartwright had been convened. It was considered that such an Expert Group should be set up immediately to oversee the National Cervical Screening Programme and to provide advice to the Minister on cervical screening." (Report of The Ministerial Review Committee on Implementation of a National Cervical Screening Programme 1989:31).

The next significant phase was the Expert Group's task of coming to grips with their role and the issues surrounding cervical screening. There appeared to be a lack of clarity about the Expert Group's role which some interviewees maintained caused problems for the group. One interviewee stated "In the sense of the Expert Group...all the Expert Group, including the chairthere was not appropriate briefing and that's not fair. As I understand it no committee member was briefed." (EG-P). The Expert Group soon came to the realisation that they needed to develop policy for the NCSP. As one interviewee stated "We struggled probably for the first six months to come to the point where we decided to write a policy. Once we acknowledged that need, and assigned someone the task, then we made incredible progress. Looking back, it took us a while to come to that stage. We didn't start off as a policy-making group." (EG-P).

The collection of important baseline information was described as a significant phase by the policy-makers. The Department of Health, on the advice of the Expert Group, commissioned research to determine the current cervical screening levels in the community and to compile a profile of unscreened women. One interviewee expressed concern that the Department of Health had not taken the initiative

in collecting baseline data on which to base policy. The interviewee stated "To me, it is ridiculous to put into place any policy at all without having a baseline of screening incidence. I found that the most ridiculous piece of non-policy I have ever found. A policy decision had been made to implement an expensive policy on cervical cancer without the base of screening incidence. We called for that immediately but the Department of Health had to be persuaded. I think that was in May (1990)." (EG-P).

The next significant phase in the NCSP policy development was the visit to New Zealand of an overseas expert on cervical screening programmes. The Expert Group advised the Department of Health to invite an Australian expert on cervical screening to New Zealand in order to review pilot cervical screening programmes in New Zealand and advise on future requirements for the NCSP policy. Dr Judith Straton arrived in New Zealand on 15 June 1990. Her visit and subsequent report which was provided to the Department in July 1990 (Straton 1990) was described as a significant stage in the policy development process. One interviewee stated "Judith Straton's report ... really confirmed that we were going in the right direction. Her visit was really important." (EG-C).

4.6 Summary

According to the interviewees the most significant event to influence the development of the NCSP policy was the Cartwright Inquiry. The publication of the Skegg recommendations in 1985 and a meeting between the Cancer Society and the Department of Health in 1986 were both significant events that paved the way for the NCSP policy. However, it was the Cartwright Inquiry that resulted in the NCSP being adopted as Government policy. The restructuring of the Department of Health with the accompanying changes in personnel was mentioned by some interviewees as a

significant event which adversely affected the development of the NCSP policy.

As well as significant events there were significant or dominant individuals who influenced the development of the NCSP policy. Members of the medical profession, Sandra Coney, Helen Clark, Ruth Bonita and Peggy Koopman-Boyden were all mentioned by interviewees as having a significant and positive influence on the development of the NCSP policy. Several of the influential individuals identified by interviewees were members of groups and organisations which supported and influenced the development of the NCSP policy. The following groups were cited as being influential and supportive of the NCSP policy: the Cancer Society, the Department of Social and Preventive Medicine in Otago and women's groups. As well as supportive groups there were non-supportive groups identified by interviewees, namely: the medical profession, the Department of Health and senior administrators in both the Department and area health boards.

There were significant phases/stages in the development of the NCSP policy, according to the interviewees. These were: the ministerial review of 1989, the Expert Group's recognition of the need for policy, the collection of baseline data on which to base policy and Dr Straton's visit to New Zealand.

This chapter has focused on the situational factors which influenced the development of the NCSP policy. The next chapter reports on the structural factors which interviewees maintained influenced the development of the NCSP policy. Structural factors refer to the more permanent elements of society and polity such as the economic base and the political system.

CHAPTER FIVE

THE STRUCTURAL FACTORS AFFECTING THE NCSP POLICY

5.1 Introduction

This chapter presents the structural factors which appeared to influence the development of the NCSP policy. Structural factors refer to the relatively unchanging aspects of New Zealand society such as the political system and the economic base. As Leichter (1979) and Hill & Bramley (1986) have stated, any examination of policy development must be sensitive to the political and social environments. An important structural factor in policy development is the role of the state. The role of the state in the provision of health care, according to interviewees is to ensure equality of access. In the case of the NCSP policy, the role of the state was envisaged to be relatively active in encouraging cervical screening on a population-wide basis. This central role which was envisaged for the state was in direct conflict with the principle of devolution from the centre to the periphery and the pursuit of a minimal state.

According to the interviewees the Government had made a prior policy commitment to implement the NCSP policy. The prior policy commitments are discussed together with the fit between the NCSP policy and other health policies. The NCSP policy differed from other policies in terms of its envisaged role for the state and the fact that the community had participated in the development of the policy.

The interviewees' opinions about New Zealand's poor economic situation and its implications for the NCSP policy

are described. Then interviewees' opinions about the economic sustainability of the NCSP policy are described as are their opinions about the top-down or bottom-up nature of the NCSP policy. Interviewees then provided their opinions about the likelihood of the future success of the NCSP policy, in terms of its implementation.

5.2 The role of the state in the Health Care Sector

The key individuals in the development of this policy viewed the State's role as pivotal in health care provision. The vast majority of interviewees maintained that the State had a major role in ensuring equality of access. As one interviewee stated "To provide access....and make sure that there are resources." (EG-C). In their opinion, the State should ensure that everyone had access to health services. One interviewee commented "The state ought to use funding to make sure that those who can't afford good services get good services and makes sure that the population stays healthy." (EG-P).

This orthodox liberal view assumes that the State has the neutral function of protecting the interests of all members of society. Thus the State will develop social policies which will promote "the public interest" (Codd, Harker & Nash 1990). The extent of state intervention is the more debatable question with *The Royal Commission on Social Policy* advocating an interventionist welfare state while the Treasury advocates a minimalist state.

5.3 The role of the state in the NCSP policy

The role of the State in the NCSP policy was described as pioneering because it was proposing a more active role in cervical screening. The provision of cervical screening services to women had traditionally been the responsibility of general practitioners. General practitioners, thus, advised women when and if they should have cervical smears

and referred those with abnormal cervical smear results to follow-up treatment. The role of the State in the above scenario was to subsidise the cost of laboratory charges for the reading of smears and to partially subsidise the general practitioners' charges to women.

In developing a policy for a population-wide cervical screening programme the State was seen as becoming more involved. The implication was that the cervical screening service being provided by the private sector at that time was not adequate and the State needed to intervene. As one interviewee stated "In a preventative health measure like screening, I don't think you can leave that to independent bodies to do because, if it requires the whole population to participate, it can only be done at a population level so there needs to be policy that is dictated and monitored centrally." (EG-P). Another interviewee commented "The State was willing to pick it up and say this was the responsibility of the public health system and that was pretty new in lots of ways." (EG-C).

The NCSP policy was a preventive health measure which traditionally did not assume the importance that treatment or curative services did. So, if it was left to the traditional policy-makers, who were dominated by the medical profession, this preventive health policy would not assume enough priority to be implemented. One interviewee commented "Unless the State becomes involved you will only get opportunistic screening¹ and we won't do anything about the death rate." (B-P). The dominance of curative services at the expense of preventive health initiatives is well documented (e.g. Powles 1973; Freymann 1975 and Davis 1981) so the view of these interviewees is supported by research.

¹ Opportunistic screening occurs when smear-takers take the opportunity to offer a woman a cervical smear test when she consults them on another health matter. Opportunistic screening tends to lead to overscreening.

The degree of involvement by the State was an issue for some of the interviewees. For example, it was said that the State should only be involved in setting the broad parameters for the development of the policy. The State should not be involved with defining the detail of the policy. One interviewee maintained that the state had jumped into the development of the NCSP policy "'Boots and All'. (The State) Determined the broad parameters and then jumped into the nitty gritty. The State was to become over-involved." (B-P). One interviewee pointed out that the state's role should be carefully circumscribed and commented "The State has an obligation to provide the framework within which screening should take place. It is interesting in terms of how far the State should go and how intrusive the State needs to be. You can offer something and if people don't pick it up that's their problem. Do you need to repeatedly bring it to their attention?" (B-P).

The central role envisaged for the state in the NCSP policy ran counter to the trend of devolution. The State was in the process of devolving many of its responsibilities to the periphery. In the Health Sector this involved a relinquishing of control by the Department of Health and the vesting of this control within the area health boards. One interviewee maintained "It (NCSP) is a national programme at a time when devolution is the order of the day. That overriding policy has influenced and perhaps obstructed the development of this policy." (EG-P). Another interviewee stated "I think it (the NCSP policy) assumes a very central role....because it needs to develop a centralised approach." (EG-P).

The move to reduce the operational functions of public sector departments was emphasised by the Treasury in its advice to the incoming government in 1987 (The Treasury 1987). Treasury's advice was that public sector departments should clearly separate "...responsibility for the provision of policy advice, regulatory and funding

activities, and operational activity." (The Treasury 1987:76). The rationale for this separation was

...major advantages in reducing tendencies to 'producer capture', giving the Government greater control over the standard of policy advice it received and the quality of regulatory and funding decisions, and providing a clearer means of establishing efficiency in production operations. The latter would also be facilitated by the greater ease of allowing consumer choice to be reflected in outcomes. (The Treasury 1987:77).

So the Department of Health's goal in attempting to divest itself of operational activities was in direct conflict with that of the Expert Group which was advising it and the Minister of Health to centrally operate and co-ordinate the NCSP. The Expert Group's advice to centrally co-ordinate the NCSP was based on empirical evidence from overseas which found central co-ordination to be a significant criterion of successful cervical screening programmes (World Health Organisation 1986). This conflict in goals created a tension between the Department on the one hand and the Expert Group and Minister on the other. One interviewee commented

...we had the support of the Minister. We didn't have the support of the hierarchy in the Health Department. ...difficulty with the relationship between the Minister and the Department. Things were pulling in two directions. The Minister was pulling in one direction and the Department was pulling in another. The Department was always sabotaging the Minister's attempts to get the programme going. (EG-C).

The Department of Health was attempting to devolve responsibility for the NCSP to the area health boards while the Minister of Health was supportive of a centrally managed and operated NCSP programme. As one interviewee stated "There was a predisposition not to have a central framework for the programme and not to keep a close eye on it. There was a belief that we should really leave it to the boards to get on with it." (B-P).

5.4 Prior policy commitments

The interviewees were of the opinion that the Government had made prior policy decisions which influenced the development of the NCSP policy. The Government's establishment of a Royal Commission of Inquiry in 1987 to investigate the treatment of women with abnormal cervical smear results at National Women's Hospital in Auckland, was perceived by many interviewees as a commitment to further action. An interviewee commented "I suppose the background of wanting to do more at the primary care level and more specifically having set up the Cartwright Inquiry, and having received the recommendations, Government was really bound to do something about it. It demanded a response." (B-P). Therefore, the NCSP policy decision was perceived as having been made by the Government prior to the establishment of the Expert Group. One interviewee stated "...a political decision had been made that there would be a programme so nobody actually examined whether there should be or not - it was accepted that that political decision had been made." (EG-P).

5.5 The fit between the NCSP policy and other policies

The NCSP policy seemed to fit with the trend towards preventive health policies (Minister of Health: December 1989) according to some interviewees. One interviewee stated "It fitted quite well (with preventive health policies), particularly with what Helen Clark wanted to do." (B-P). Another interviewee commented "It was comparable. Fitted with preventive health campaigns." (B-P).

On 14 December 1989 the Minister of Health, Helen Clark, produced the document *A New Relationship: Introducing The New Interface Between The Government and The Public Health*

Sector which identified cervical cancer as a priority health initiative. Thus the Government was committed to reducing "the incidence of invasive cervical cancer and the cervical cancer death rate." (Minister of Health December 1989:27). This policy decision was an indication that the NCSP policy fitted with the Government's overall health policy.

The NCSP policy required central co-ordination and so did not fit with the widespread policy of devolution of operational activity to the periphery by state institutions as mentioned previously. This fundamental difference between the widespread policy of devolution and that of central co-ordination within the NCSP caused problems for the policy-makers. As one interviewee stated "It didn't fit in as far as we know, especially as far as devolution goes. That was one of its major problems. It assumed a more prominent centralised role." (EG-P). Another interviewee maintained "The main dissonance is that the whole Health Department is moving towards regionalisation and this policy is centrally driven." (EG-P). Another interviewee remarked "It was quite contradictory to some of them (policies) because it required national co-ordination at a time when we were leaning towards more regional autonomy." (EG-P).

Another stated difference between The NCSP policy and other policies was the amount of consumer input into the policy development process. One interviewee stated "To some extent it was very different because it had much more of a consumer input than things that have happened before and since. So it was extremely progressive in giving a great deal of weight to the consumer voice. In the past, the Department tended to impose policies on people. So this programme was different because it proposed co-ownership of responsibility." (EG-C).

5.6 The New Zealand economy: its influence on the policy

New Zealand has a welfare state (Shirley 1986) which has come under considerable scrutiny as the economic situation within the country has deteriorated. Since the mid-1970s many Western nations within the OECD countries have experienced what has been described as "fiscal crises" (Hill & Bramley 1986). The cause of these fiscal crises has been attributed mainly to increased public expenditure by the welfare state although there could be a number of other causes (Hill & Bramley 1986).

New Zealand's fiscal problems have been attributed to the increase in coverage of transfer payments, including superannuation and the Domestic Purposes Benefit, and the growth in debt servicing (Treasury 1987). The thrust is to contain costs as much as possible to ameliorate the fiscal crisis.

The interviewees described New Zealand's economic conditions as being rather dismal. All agreed that New Zealand was running out of money but not all agreed that this adversely affected the NCSP policy. Some interviewees maintained that the NCSP policy had been allocated large amounts of Government funding. The large funding allocations made were detrimental to the policy because it generated a degree of envy which became directed at the policy, particularly as the economic conditions worsened. As one interviewee stated "It was protected. It was a preferred policy. There was big expenditure involved which could also make it vulnerable to being chopped." (B-P). New Zealand's poor economic circumstances did not adversely affect the NCSP policy. As one interviewee commented "Didn't influence it at all. Just didn't figure. It was deemed to be a priority and the money was found." (B-P). Another interviewee stated "...it (policy) didn't seem to be that adversely affected." (B-P).

While the bureaucrats/politician group maintained that New Zealand's poor economic situation did not adversely affect the NCSP policy, some members of the Expert Group disagreed. One interviewee maintained "Small amount of money available for the development of this policy. Large push to rely on traditional services. Economic constraints mean that we are still pushing the use of services that we know some women will not use." (EG-P).

The majority of policy-makers did, however, agree that economic considerations were not particularly prominent during the development of this policy. As one interviewee maintained "...the shape of the economics of it were very largely kept, I believe, within the political sphere - within the Minister's office and not outside that group." (EG-P). Another interviewee stated "Although we recognised certain concerns related to economic issues, I don't think we really had gone into them at all." (EG-P).

Several interviewees stated that no consideration had been given to the economic impact of the Expert Group's policy decisions because it was always assumed that funding was not an issue. In other words, the Minister's announcement that a large amount of money had been allocated for cervical screening had lulled them into thinking that "money was no object". As one interviewee stated "We've got to make an incredibly good case for instituting a new programme - something which I and the committees didn't even consider because as far as I was concerned and I think the committees as well, a political decision had been made that there would be a programme so nobody actually examined whether there should be or not - it was accepted that that political decision had been made and all we were there to do was to implement it." (EG-P). So the fiscal implications of aspects of the policy were not considered. The fact that fiscal implications were either a low priority or not considered in the development of this policy tends to suggest that this policy was more concerned

with legitimation than with development of an efficient and cost-effective policy.

Marxists maintain that the logical outcome of a capitalist mode of production is crisis (O'Connor 1973). The welfare state was established to ameliorate the inequities associated with capitalism. However, as the economic problems express themselves within the community as a whole, for example, by rising unemployment, there exists a crisis of legitimation which the state must resolve.

Legitimation refers to a government's ability to retain popular support (Codd et al 1990). Political parties promulgate specific policies which seek the support of the people. In a democracy, governments are elected partly on the basis of the policies which they advocate. Once in power, governments seek to remain in power by engendering mass support for their policies. This mass support legitimates the existing system of government and ensures its continuation (Codd et al 1990).

When governments no longer enjoy popular support there exists a crisis of legitimation and it becomes difficult, if not impossible, to implement their policies (Habermas 1976). This happened to the National Government in 1984 and resulted in the election of the fourth Labour Government. The rhetoric of the policies of the Labour Government of 1984 appeared to espouse traditional corporatist tendencies which are normally associated with industrial relations but are used in this context to describe a political theme or ideology which influenced the wider social policy arena.

The political context within which the NCSP policy was to be developed was one characterised by a crisis of legitimation. The Government's response to this was to espouse corporatism, at least initially and mainly in a rhetorical way until Roger Douglas's restructuring of the

economy came into direct conflict with this idea. Corporatism as a traditional Labour approach, generally, lost credibility as its political practicability came into question and did not assume importance again until Labour's second term of office in 1987 (Easton 1989). Even in Labour's second term of office, corporatism was espoused only in selected circumstances. For example, the *Report of The Hospital & Related Services Taskforce* (Gibbs, Fraser & Scott 1988) which made recommendations to the Government about restructuring the Health Sector, did not embrace corporatism. The rejection of corporatism was also evident in the education sector with the report *Administering For Excellence (Picot Report)* (1988) advocating a strong non-participatory managerial stance.

Helen Clark was a consistent supporter of corporatism, being a member of the traditional corporatist faction within caucus (Easton 1989). As Minister of Health she was able to put into practice her desire to involve the community in policy-making. The scene was thus set for the promotion of community participation into the NCSP policy-making process. It was not surprising, therefore, that the group which was to develop the policy for the NCSP was heavily representative of consumers. This involvement of consumers in policy-making was, however, unusual and not reflective of the general policy-making processes of the Labour Governments of 1984 and 1987, in spite of the Governments' corporatist rhetoric.

Some interviewees maintained that there had been insufficient attention paid to the economic impact of the NCSP policy as it was developed. One interviewee stated "...the idea was to have a Rolls Royce service....As time went on it became obvious that we could not afford that sort of thing." (EG-C). Another interviewee remarked "...so many changes kept happening... what was really missing....was that there had been no information about the actual economic costs of cervical cancer and what could be

achieved with a programme. There were political pressures to be seen to be doing something without doing the homework first." (EG-P). This again seems to indicate that the NCSP policy was developed in response to a crisis of legitimation.

The majority of interviewees thought that the NCSP policy was economically sustainable. Reference was made to a cost-benefit analysis (Cox 1989) which found that a NCSP based on a three yearly smear interval was as cost-effective as other screening and disease prevention programmes. One interviewee stated "I think yes (the NCSP is economically sustainable) but it will depend on the will of the government." (EG-C). Another interviewee maintained "...if you don't have this policy you are going to be paying out more anyway, in treatment, lost productivity. So I think it is economically sustainable." (EG-C).

The NCSP would be economically sustainable if the rate of overscreening could be reduced, according to one interviewee. Overscreening is defined as screening women who have normal smear histories more frequently than once every three years. The cost to Vote:Health of reading these superfluous smears could be reduced. This interviewee stated "...should be economically sustainable....if there were disincentives for unnecessary overscreening." (EG-P).

So most interviewees maintained that the NCSP was economically sustainable, as exemplified in the following comment, "You always have money for some things. It just depends what comes to the top of the pile." (B-P). Some interviewees suggested that economic sustainability should constantly be evaluated. One interviewee stated "It's a question of priorities. It constantly needs to be examined to see how well it stands up to other policies in terms of priorities. You have to be constantly looking and revisiting policies." (B-P). Another interviewee remarked

"I think demonstrably you've got to show that a programme is cost-effective to continue running it....." (EG-P).

5.7 Top-down or bottom-up policy-making process?

The opinion of interviewees was that while the NCSP policy-making process was both top-down and bottom-up it was more top-down than bottom-up. Some interviewees described the process as both top-down and bottom-up simultaneously. One interviewee stated "I would say that it was fifty fifty." (EG-P). Another interviewee commented "A mixture of both." (EG-C). Another interviewee remarked "Both simultaneously. The meeting point was within the Expert Group and the battle raged within it." (B-P).

The NCSP policy-making process was described as top-down because it was largely driven by the Minister of Health. As one interviewee stated "A bit more top-down than bottom-up. To be successful it must be bottom-up. It has been pushed down onto the professionals and Maori women." (EG-P). Another interviewee commented "I'd like to say that it is broadly bottom-up but I still believe that it is broadly top-down. It sets out ways in which a broad based approach can be used but basically it was really top-down." (EG-P).

The need for central co-ordination meant that the policy would necessarily be top-down. The policy was decentralising and bottom-up in its development but centralising and top-down in its implementation. As one interviewee stated "Top-down. This is one of the contradictions of this programme. Once you see how cervical screening works, there has to be an overall policy which may contain things like the register (computerised management tool for cervical smear data), which the grass-roots may not be comfortable with. But if it's to work for them there has to be something like the register. This is contradictory but has to be." (EG-P). Another interviewee

maintained "The top-down included quick decisions made often in response to things that were put forward from the bottom-up." (EG-P). One interviewee maintained that the policy-making process was top-down because there was a lack of consultation between some policy-makers and their constituencies. This interviewee stated "...top-down because, while the screening (Expert) group was meant to be representative, constituents had not set up regular reporting back mechanisms with their own groups." (EG-P).

As a response to a crisis of legitimation, the state tends to devolve responsibility and accountability downwards (Codd et al 1990). To enable the change in function, state institutions become restructured. The Department of Health was no exception, undergoing several restructurings during the Labour Government's two terms of office in 1984 and 1987. A major theme of the restructurings was the devolution of Departmental functions to the periphery, the area health boards.

A minority of interviewees described the policy-making process as bottom-up because it had a great deal of consumer input and support. One interviewee stated "I think as much as any policy of government ever is bottom-up this had the potential to do that." (EG-P). Another interviewee commented "Well I think a fair proportion of it (policy) wascertainly bottom-up." (EG-C). As some researchers (e.g. Child 1984; Corson 1986) have observed, to be successfully implemented a policy must have the support of policy administrators which implies, in the NCSP policy, more bottom-up input.

5.8 Will the NCSP policy be successfully implemented?

Interviewees were divided in their opinion about whether or not the policy would be successfully implemented. Half the interviewees maintained that the policy would be

successfully implemented because women would work to ensure that it was. As one interviewee stated "Yes, well we (women) will jolly well try and make sure it is (successfully implemented)." (EG-C). Another interviewee commented "I'm optimistic in a broad sense." (EG-P). Another interviewee maintained "Yes I do (think it will be successfully implemented) because of the dedicated workers both at national level and area health board level." (EG-P). Another interviewee commented "...I remain optimistic, I believe that it will be implemented successfully but perhaps not as successfully as we had hoped." (EG-P).

Fifty percent of the interviewees were unsure whether the policy would be successfully implemented. Reasons for this uncertainty were: insufficient commitment to central co-ordination; the confounding influence of the new health reforms introduced in July 1991 and the voluntary opt-on nature of the cytology register. One interviewee commented "No. I don't think there is sufficient commitment to central policy co-ordination." (B-P). Another interviewee commented "The big unknown is what is going to happen with the new health reforms. I don't see how it fits into the health restructuring." (EG-C). Another interviewee stated "Without the necessary legislation (for an opt-off register) the programme is at risk. It could become very costly." (EG-P).

On the whole, then, interviewees thought that the policy could be successfully implemented if there was sufficient political commitment to it and if certain technical aspects of the register were changed. There was, however, a concern expressed that the NCSP would not fit within the proposed health reforms of the 1990 National Government.

5.10 Summary

The structural factors, those relatively unchanging aspects of society such as the political system and the economic base, which influenced the development of the NCSP policy were the focus of this chapter. The role of the state was reported to be pivotal in the NCSP policy as it was envisaged to be more active and centrally driven. This more active role for the state fits with the orthodox liberal view that the state should be involved in developing social policies which promote the public good. The state's increased responsibility envisaged by the policy-makers in the Expert Group did not fit with the principle of devolving responsibility from the centre to the periphery. Thus there was a tension between the Expert Group members and the bureaucrats within the Department of Health.

According to the interviewees the Government had made a decision to implement Cartwright's recommendation to establish a NCSP and therefore no-one actually evaluated the need for one. The NCSP policy fitted well with other preventive health policies but it did not fit with the policy of devolution of responsibility from the centre to the periphery. The NCSP policy was different from many other social policies because there was a significant degree of community participation in the development of the policy. Community participation fitted in with the Labour Government's advocacy of corporatism in the industrial relations arena.

New Zealand's economic situation was not good, according to the interviewees but this did not appear to disadvantage the NCSP policy. Interviewees were mainly of the view that there was a drive to curb public expenditure in New Zealand but this did not affect the NCSP policy. Interviewees further maintained that the Government made the decision to

establish a NCSP. This top-down decision was not evaluated by policy-makers who did not particularly consider economic aspects of the NCSP although this did not disadvantage the policy. As economic considerations did not appear to apply to the NCSP policy it tends to suggest that the policy was more concerned with legitimation than with efficiency and effectiveness. This view on legitimation is supported by the interviewees' opinion that the NCSP policy was more top-down than bottom-up.

Interviewees were divided in their opinion about whether the NCSP policy would be successfully implemented. Successful implementation would depend on future political commitment and support for further policy adjustments.

This chapter has focused on the structural factors which influenced the development of the NCSP policy. The next chapter focuses on the cultural/ideological factors which interviewees reported influenced the NCSP policy.

CHAPTER SIX

THE CULTURAL/IDEOLOGICAL FACTORS AFFECTING THE NCSP POLICY

6.1 Introduction

This chapter presents the findings in relation to the cultural/ideological factors which influenced the NCSP policy development. Cultural/ideological factors refer to the values, assumptions and ideologies which underpin the development of the NCSP policy.

The interviewees attempted to ensure that the NCSP policy reflected New Zealand's divergent cultural values. Interviewees discussed the cultural values which were most prominent in the NCSP policy and the political ideology of the time which fitted with the NCSP policy. According to interviewees the Treaty of Waitangi influenced the policy-makers as they attempted to satisfy the partnership requirements contained in the Treaty.

The relatively intrusive role envisaged for the state in the NCSP policy had moral implications according to interviewees. These moral implications are discussed here.

The language of the market place which has permeated the State Sector was discussed by interviewees. The majority of interviewees appeared to accept the market jargon but not all the interviewees were comfortable with it. Their views on some of the jargon used in the market place are discussed.

6.2 New Zealand's divergent cultural values: are they reflected in the NCSP policy?

It appeared that the policy-makers did attempt to ensure that the NCSP policy reflected the divergent cultural values in New Zealand society. Interviewees thought that on the whole, the policy was reasonably culturally sensitive, particularly to Maori and Pacific Island women. One interviewee stated "I think we attempted to (develop a culturally sensitive policy) but in the end what has come out is structurally probably not as culturally sensitive as we had planned." (EG-P). Another interviewee commented "In terms of most policies, it's quite culturally sensitive." (EG-C). Another interviewee maintained "Yes I think we haven't done the whole thing we would like to do but yes we had some things put in." (EG-C). Another interviewee remarked "The best that could have been done was done here." (B-P).

While the policy-makers maintained that they had attempted to ensure that the NCSP policy was reflective of New Zealand's diverse cultural values, some were uncertain about the achievement of this goal. As one interviewee stated "It was the aim but there have been instances where this will not be totally achieved." (EG-P). Another interviewee commented "...I think it's a good attempt." (EG-P).

It would seem, therefore, that while the policy-makers thought that they had developed a policy which was culturally sensitive, they were uncertain whether they had succeeded. The cultural sensitivity or otherwise of the NCSP policy would require validation by consumers. Interviewees were in no doubt that successful implementation of the policy nationally was dependent on the policy being culturally sensitive. As one interviewee commented "To work it will have to (be culturally sensitive)." (B-P).

6.3 The prominent cultural values in the NCSP policy

The cultural values that were reported as being most prominently embodied in the NCSP policy were: the health values of the biomedical model and sensitivity to women's needs. On the issue of the biomedical model one interviewee stated "The cervical screening programme is a product of the Pakeha medical culture and as such it endeavours to impose quite a large sector of the population a certain systematic check which is done in a very medical cultural way. Within the medical framework, there is a sub-culture of public health." (EG-P). Another interviewee commented "NCSP had its origins in the medical model..." (EG-P).

Women's values were stated as being dominant within the NCSP policy. One interviewee stated "...sensitivity to women's needs." (EG-C). Another interviewee commented "The recognition that women have different perspectives on their bodies and in some cases prefer services that are provided in ways that are more comfortable for them." (EG-P). Another interviewee maintained "...a lot of respect for women in the policy. There was a partnership model right the way through both with Maori and Pakeha and also between providers and users." (EG-C).

The NCSP policy as reported by interviewees was sensitive to women's needs and acknowledged that not all women are satisfied with the traditional general-practice based cervical screening services offered. Therefore the policy statement recommended that alternative cervical screening services should be provided by area health boards (National Cervical Screening Programme: Policy Statement of The National Cervical Screening Programme Expert Group 1990). Alternative services could include a variety of: smear-

takers, including women and "lay" persons¹ and venues, including free or low-cost clinics. The variety of service options for women was an attempt to ensure choice and thus theoretically to empower them (The National Cervical Screening Programme Expert Group: 1990).

Other cultural values which interviewees stated were embodied within the NCSP policy related to, informed consent, confidentiality, the Treaty of Waitangi and egalitarianism. One interviewee stated "The particular cultural values embodied most prominently in this policy relate to the question of confidentiality and informed consent." (EG-P). Another interviewee commented "The Treaty of Waitangi and the values that are there. We tried to encourage each cultural group to develop plans for its own needs." (EG-P). Another interviewee remarked "Egalitarian. It has a little of everything in it. It is a personal complete slice of life. It has ethnic problems and values, physiological values and financial values." (B-P).

Health as a value underpins the NCSP policy according to some interviewees. One interviewee remarked "Given that this is a particular women's health issue there are specific health values in the policy." (B-P). The definition of health in the policy statement is described as the absence of disease with the aim of reducing the morbidity and mortality associated with cervical cancer (National Cervical Screening Programme: Policy Statement of the National Cervical Screening Programme Expert Group 1990).

6.4 The NCSP policy and popular support

Interviewees were asked whether the NCSP policy had popular support. The NCSP policy was reported as generally having

¹ Lay persons are defined as all non medical personnel. Thus nurses are defined as lay persons in this context.

the popular support of the community and especially of women. One interviewee stated "Policy (NCSP) does have popular support." (EG-P). Another interviewee maintained "I think that amongst women, yes." (EG-C). Another interviewee commented "Yes I do. It's one of those rare things that the community thinks is rather a good thing. There is certainly a wide awareness of it." (B-P).

The policy appeared to be highly symbolic to women who reacted strongly to any threat to curtail the policy. For example, in October 1990, the Labour Minister of Health publicly announced the allocation of \$4.5 million to area health boards for cervical screening (Minister of Health: October 1990). In November 1990 the newly elected National Government placed all new policies on hold while it reordered policy priorities. The ensuing flood of letters (personal observation) to the newly appointed Minister and Associate Minister of Health was one indication of women's strong support for the policy.

6.5 Did the NCSP policy reflect the political ideology of the time?

All interviewees stated that the NCSP policy fitted with the political ideology of the time. The political ideology of the time was reported by interviewees as including community involvement in policy-making, an acknowledgement of women's health as a priority and a shift to preventive as opposed to curative health services. The Government had made a commitment to preventive health initiatives in several health areas including cervical cancer (Minister of Health 1989).

On the issue of community involvement in policy-making one interviewee commented "...at that time, yes, there was an encouragement for the community to be involved in policy-making..." (EG-C). Another interviewee noted "The

government of the time had made a commitment to establishing policies in health goals and targets and things measurable and this fitted into that. Also it was committed to consultation." (EG-P). A third interviewee stated "It seemed to me that there has been a move for the individual to be empowered to seek their own health care rather than this be handed down from health professionals. So it fitted with that." (EG-P).

The political rhetoric, at that time, included corporatism which supported the involvement of consumers, particularly in the industrial sector, in all forms of decision-making (Easton 1989). Corporatism espoused the theme of consensus, particularly in the formulation and implementation of government policies (Easton 1989). The corporatist rhetoric was not particularly evident in many social policies² so the NCSP policy was an exception.

The Government's shift to preventive health policies from the usual curative policies was noted by interviewees as reflective of the political ideology of the time. One interviewee stated "Helen Clark has an interest in and a bias towards public health. The screening programme fitted in with Helen Clark's overall vision of health as being much broader than hospitals or services." (EG-C). Another interviewee noted "It clearly fitted within that general goal of support of health promotion and primary prevention." (B-P).

Political support for the women's movement was seen by interviewees as being reflected in the Government's commitment to the establishment of the NCSP. One interviewee commented "There had been quite a bit of agitation about services generally and the insensitivity of services to women's needs. The Cartwright Inquiry was about women's health rather than cervical cancer." (B-P).

² Corporatism as a theme in social policy development is referred to in Chapter Five, pages 85-86.

Another interviewee maintained that the political ideology of the time reflected "Possibly a public health philosophy and a woman's health philosophy." (EG-P). Another interviewee remarked "NCSP had its origins in the medical model which I would argue is a political model. Has dominance. Focus is on the cervix and not the whole woman. For the purposes of obtaining funding that model was convincing but the covert model is the women's health model." (EG-P).

6.6 The Treaty of Waitangi and the NCSP policy

Interviewees reported that the NCSP policy-makers took the Treaty of Waitangi into consideration during the development of the policy. The Treaty of Waitangi was an issue of great concern to the majority of interviewees who maintained that every attempt had been made to duly consider the needs of Maori women. Maori women have three times the rate of cervical cancer as Pakeha women and so were identified as a priority group in terms of the NCSP policy.

The issues relating to the Treaty of Waitangi which arose during the policy development process were mainly about Maori desire for more control over their own health care. One interviewee maintained "They wanted control of their own services. There was ill-feeling about the health status of Maori women and having been researched in the past." (EG-C). Another interviewee stated "Maori also perceive they want more control over their own health care systems." (EG-P).

The Maori perception of health is more wholistic than the current New Zealand, Pakeha dominated system allows. As one interviewee stated "The whole issue of Pakeha imposing a system on Maori was a problem. Cervical screening is not

the most important issue for Maori women - it became obvious." (EG-P).

According to some interviewees Maori are not as well informed as Pakeha about some preventive health measures. As one interviewee maintained "...they had special education needs because there was a level of ignorance which was not general among non-Maori women. If we were to make sure that they enjoyed the same things in New Zealand as non-Maori then we had to be prepared to put in more resources." (EG-P). Another interviewee was uncertain about the reasons that Maori women were not accessing cervical screening services. The interviewee commented "Why aren't they screened? What's wrong with the system that they aren't getting screened? I think those issues are quite relevant." (EG-P).

The interviewees maintained that Maori women were adequately consulted in the development of the policy even though some of their requests were not accepted. For example, the whole Expert Group supported the Maori representatives' request for the appointment of five to seven National Maori cervical screening co-ordinators. The Minister of Health rejected this recommendation of the Expert Group (Minister of Health October 1990).

The majority of interviewees, including all consumer representatives, were of the opinion that the NCSP policy satisfied the partnership requirements contained in the Treaty of Waitangi. One interviewee commented "...they (Maori and Pacific Island women) had a substantial input into the direction in which the policy was developed." (EG-P). Another interviewee stated "I feel that we did (satisfy the partnership requirements contained in the Treaty of Waitangi).....the policy did. In the area of Maori co-ordinators, we failed to convince the people in power that that was a good idea. So we didn't satisfy the partnership requirements here." (EG-C). Another

interviewee remarked "Well yes it went a long way towards that. There still is a lot of stuff that needs to be done and the difficulty is that people from different areas in Maoridom seem to have trouble coming to discuss with each other." (EG-C). Another interviewee maintained "Yes essentially but it got highjacked. The policy did try to be fair...." (B-P).

A minority of interviewees, all of whom were professionals, were of the opinion that the NCSP policy-making process may not have satisfied the partnership requirements contained in the Treaty of Waitangi. One interviewee stated "Barely because of the lack of sharing of resources." (EG-P). Another interviewee commented "I'm not sure. My impression is that we did try to meet the Treaty obligations." (EG-P). Another interviewee described the situation as follows, "If you interpret partnership in terms of giving out the money then no we didn't. If, on the other hand, you say that this is a bicultural society and we are distributing our health services through the area health boards for Maori and Pakeha alike and if Maori health improves then yes we have." (B-P).

Some interviewees pointed out, however, that the Health Sector is a Pakeha system and is not particularly flexible. One interviewee commented "...you are having to use the medical cultural framework...This is more problematic for non-Pakeha people." (EG-P). Thus, while Maori women were consulted and the best that could be done was done, the Health Sector remains limited in its ability to meet the needs of Maori women. So within the constraints imposed by the Health Sector, the NCSP policy did attempt to meet the needs of Maori women. As one interviewee maintained "...as much as we could in the structure, yes (we satisfied the partnership requirements contained in the Treaty of Waitangi)." (EG-P).

6.7 The social and moral implications of the NCSP policy

Many social and moral implications of the NCSP policy were reported by interviewees. These included: the relatively intrusive role of the state in the NCSP; equity; the issue of confidentiality of the register data; risk of over-reassuring women and the eminent preventability of cervical cancer.

The main moral implications related to the relatively intrusive role envisaged for the state in the NCSP. As one interviewee stated "...the State has a responsibility to ensure that fewer women develop or die from cervical cancer." (EG-P). The majority of interviewees decided that it was the role of the State to be responsible for the health of individuals. Just how intrusive the State should be in performing this role was the dilemma. One interviewee stated "There must come a point where you allow individuals responsibility for their own health. My own view is that some people just don't get around to getting things done, who are frightened by the environment. We do need to be forthcoming in order to help them to make decisions which are in the interests of their own health. It's a question of societal judgement as to how far you go." (B-P). Another interviewee stated, "One of the implications is that the State is moving into screening and is making a statement by wanting everybody to be involved in screening. It is relatively coercive or inclusive of everyone. We are attempting to seek out every woman and pressure her into having a smear. The State is therefore coming in and interfering a bit more with an individual's right." (EG-P).

The notion that the State should intervene in, for example, health care services assumes that the health care system is not accessible to parts of society, for whatever reason. One interviewee reported that there was an element of

redistribution of wealth in the NCSP policy as it focused on providing services to those women most at risk of the disease. The interviewee stated ".....that the State accepts responsibility to prevent unnecessary death. ...one assumes that those at more risk of developing the disease will not normally be screened so there is an element of redistribution.....there is an equity issue here." (B-P). Another interviewee commented, "The equity (issue) one is the primary one. You know there is a lot of screening going on out there but some people are getting screened too often, costing everybody, and other people are sitting on a time-bomb because they are not in the system. Critical aspect for me was how do you get to the people down the line who need affirmative action from the programme. This is the primary goal, given that your aim is the prevention of unnecessary death. The key aspect of policy to tackle is how do you make the service acceptable to these disadvantaged women." (B-P).

On the other hand, the view that the State should not intervene assumes that the health care system is accessible. If individuals don't gain access to the system, it is their own personal preference. Such a view is problematic because accessibility to the health care system cannot be assumed (Davis 1981).

The role of the State in redistribution is described by liberal democratic theorists as being mediated by market processes which determine access to services (e.g. Room 1979). According to liberal economic theory the State's over-involvement in redistribution is due to the rise of democracy (Mill 1975; de Torqueville 1954). Liberal theorists describe democracy as a process in which competing political parties vie for mass support at election times (Schumpeter 1947). In the process of vying for popular support, political parties promise social benefits which, if carried out, lead to inflationary expenditure by the State (Brittan 1977).

Market liberal theorists argue that the market processes are better able to distribute resources within the community as social policies cause overexpenditure by the state and thus result in a fiscal crisis (Hill & Bramley 1986). Democratic liberal theorists explain social policy development as the process of democracy. Democracy functions to impose stabilizing influences on both the market place and the political system (Galbraith 1958). This view acknowledges the short-comings of the market system and sees the growth of the Welfare State, which underpins much social policy development, as ameliorating some of these short-comings.

Privacy was described as being important to maintain as the NCSP policy recommended the use of a computerised register of women. It would be morally wrong, for example, if this register was not kept highly confidential and private. One interviewee stated "Concept of privacy in terms of the register. Worries me that we are encouraging compliance." (EG-P).

One interviewee questioned the ethics of possibly over-reassuring women that they were safe as long as they had a cervical smear test. The interviewee stated "Tends to encourage women that if they go along to their health professional they will be safe. Isn't necessarily so." (EG-P). Cervical screening has been found to be highly effective at preventing cervical cancer (Skegg et al 1985). However, there will always be cervical cancers and pre-cancers that are missed by cervical screening or not followed-up. Therefore, informing women that they are protected from a deadly disease by participating in a NCSP could be misleading.

Several interviewees maintained that the State had a moral obligation to support the NCSP policy because cervical cancer was one of the few cancers that is eminently

preventable (Skegg et al 1985). So the State should be responsible for reducing the number of deaths from cervical cancer. One interviewee stated, "The State has a moral obligation to support the programme because this is the one cancer that we can do something about. It would be callous not to do it." (EG-C).

6.8 The language of the market-place

The definition of "consumer" did not pose a problem for the majority of interviewees. Most interviewees would agree with one respondent's statement "The (consumer is the) user of the services in the broadest sense. In health the consumer is the public." (B-P).

Three interviewees expressed a dislike of the term "consumer". Two interviewees preferred to use the terms "customer" and "citizen" while the third had no alternative term to offer. One interviewee stated, "I prefer the word citizen. A citizen is a human being who is part of society who has rights and obligations. A consumer is someone who devours services. How much they devour relates to how much they can afford or grab." (EG-P).

While not offering any alternative, one interviewee did not like the use of the term "consumer", saying "Consumer is a term I'd rather not use. Indicates passivity and that health is a commodity. That there is consumption and production. So you have a provider or a producer. That is not the way health works, to me. Someone who uses the health service is not, to me, a consumer." (EG-P). The feeling of discomfort associated with the term "consumer" may well reflect an ideological position which views the provision of health care as a public good. Thus the recipients of health care are not viewed as consumers because health care is not bought but provided as of right.

Another interviewee commented, "I like to talk about customers. Anybody who has expectations of a system in any way is a customer. Some customers are more significant than others in terms of the weight that you attach to their expectations." (B-P).

Thus while the majority of interviewees agreed on the definition of "consumer", not all interviewees were satisfied with the use of the term. It appeared that for the dissatisfied interviewees the term "customer" had connotations that did not fit with their perception of the role of a member of the community in relation to the health care system.

The term "consumer" did not appear to appeal to Peters & Marshall (1988) who maintained that New Zealanders faced the choice of being either consumers of welfare who would purchase social services or members of communities who collectively identified and solved social ills. According to Peters & Marshall (1988) the ideology underpinning Treasury's policies promoted individualism over collective activity. Public and social policy involves decisions made by the state which relate to society as a whole (Hill & Bramley 1986). Thus, public and social policy connotes community collectiveness. As such the terms public and social policy are at odds with the term consumer which connotes individualism. Titmuss (1973) maintained that social policies ought to promote an individual's sense of identity, participation and community. The notion that social policies are concerned with collectiveness and the promotion of the well-being of all members of society by redistributing resources to those who lack them, does not fit with individualism. In other words social policies deal with communities not individuals. So to introduce the term consumer into the social policy arena is paradoxical. While recognising that the term consumer is not a particularly appropriate term, consumer will be used throughout the rest of this thesis because it was

extensively referred to during the interviews and in the literature.

Interviewees were asked to define "professional" and there were a variety of definitions with the main emphasis being placed on the provision of service. As one interviewee stated "A provider of the service." (EG-P). Another interviewee maintained "Basically they deliver the service." (B-P).

All interviewees agreed that professionals were individuals who were trained and thus were technically expert at providing services to consumers. One interviewee commented "...someone who has undertaken an educational programme and usually has some form of registration or licensing granted by a legitimate body." (EG-P). Another interviewee remarked "Someone who has been trained to do a specific task and who belongs to a professional body which maintains standards." (EG-P). A third interviewee stated "...the professionals are trained and have expertise in areas and they help the things to happen so that the consumer receives the services." (EG-C). Thus interviewees were of the opinion that professionals were educated in specific areas, were licenced or registered, belonged to a professional body which maintained standards and delivered the services to consumers.

On the whole the NCSP policy ran counter to Treasury's (1987) ideology which supports a minimal state and concomitantly highlights fiscal responsibility. The NCSP policy included significant state involvement, was demand led and therefore fiscally risky.

6.9 Summary

This chapter has focused on the cultural/ideological factors which influenced the development of the NCSP

policy. The policy-makers were satisfied that they had made every attempt to ensure that the NCSP policy reflected the divergent cultural values in New Zealand society. Most policy-makers were particularly keen to ensure that the policy reflected women's values and satisfied the partnership requirements contained in the Treaty of Waitangi. According to interviewees the NCSP policy was reflective of the health values of the biomedical model and appeared to have the popular support of the community at large.

The majority of interviewees were satisfied that the central and relatively intrusive role envisaged for the state in the NCSP policy was justified and in the interests of the population of women because there was an attempt to ensure equity of access to cervical screening services. The confidentiality of the computerised data was problematic for some interviewees and one interviewee pointed out that the state could be over-reassuring women that they were safely protected from cervical cancer if they had a cervical smear test.

The language of the market place was disliked by a minority of interviewees. This language does not fit well with the whole notion of social policy. Social policies imply social collectiveness and a sense of community. Such collectiveness does not fit with the individualism espoused by the market philosophy and articulated in the language or jargon used in the market place.

This chapter has focused on the cultural/ideological factors which influenced the NCSP policy during its development. The next chapter presents the research findings in relation to the environmental factors which influenced the NCSP policy. Environmental factors are those factors including the media which are outside of a political system and yet still have an impact on a policy.

CHAPTER SEVEN

THE ENVIRONMENTAL FACTORS AFFECTING THE NCSP POLICY

7.1 Introduction

This chapter focuses on the environmental factors which influenced the development of the NCSP policy. Environmental factors refer to those factors which are external to the political system yet still have an impact on policies. Environmental factors in this case study included the international events, policies, agreements and obligations which influenced the NCSP policy. Interviewees noted that some countries, particularly those with a welfare state, tended to influence New Zealand health policies.

The media had an interest in cervical screening and the NCSP since the publication of the Metro article in 1987. That interest has remained unabated since then.

7.2 International events which influenced the NCSP policy

The interviewees maintained that the cervical screening programmes in other countries, particularly those with a welfare state, were central influences in the development of the NCSP policy. As one interviewee commented "The existence of other programmes overseas.....showed it was possible to do something and get good results from those programmes. We looked at the overseas research very thoroughly. All the important aspects of the policy came from overseas programmes." (EG-C). Another interviewee maintained "Tend to look to those countries with a Welfare State." (B-P). A third interviewee stated that New Zealand

tended to be influenced by "Countries with a similar orientation to ours, where the State has a role to play...." (B-P).

The international events which influenced the NCSP policy, therefore, related to successful cervical screening programmes overseas. As one interviewee remarked "Experience of other countries with success of screening. These events have been central to the development of this policy." (EG-P).

7.3 The international social policies which influenced the NCSP policy

The influential international social policies most commonly identified by interviewees were welfare State policies and policies involving the women's movement. On the issue of the Welfare State one interviewee sounded a note of caution "We need to understand that they (countries which tend to influence New Zealand policy-making) have very well developed Welfare States. If we are going to uplift and transplant systems from their countries, we have to be aware that their contexts are different from ours." (B-P).

Another interviewee echoed this cautionary note about New Zealand's tendency to be influenced by Nordic cervical screening policies when some of the integral aspects to success are absent in New Zealand. This interviewee commented "I don't think the New Zealand policy has sufficiently embraced the lessons of other countries e.g. the need for a population based register, and a unique health identifier which is the hallmark of all the successful programmes elsewhere. (EG-P). "Another interviewee stated "We don't have a single comprehensive national patient index. It's a big disadvantage." (B-P).

While the social differences between countries were acknowledged by another interviewee this did not appear to be a cause for concern for one interviewee who stated "In Scandinavia, they have a pretty rigorous register of women who have cervical smears. They don't seem to mind!" (EG-P).

The women's movement, particularly in the Western nations was also a significant influence in the development of this policy. One interviewee stated "It (women's movement) made it possible for this to be taken seriously. I suspect that this would never have become an issue if women had not become more assertive about their health needs and care and services that they wanted. Cartwright of course, helped here. It made it clear that women were entitled to be treated with dignity." (B-P).

7.4 The international agreements and obligations which influenced the NCSP policy.

The majority of interviewees could think of no international obligations or agreements, other than New Zealand's links with the World Health Organisation (WHO), which might have influenced the development of the NCSP policy. Three interviewees described the Alma Ata Declaration and the Ottawa Charter as the major international agreements which influenced the NCSP policy¹. They thought that New Zealand's links with the WHO implied a certain commitment to the above international health agreements. As one interviewee stated "We have a general obligation under WHO that accepts matters as policy and asks the member countries to do something about specific issues." (B-P). Another interviewee stated "Alma Ata and the Ottawa Charter are moral obligations rather than legal

1 The Alma Ata Declaration of 1978 and the Ottawa Charter are both international agreements made by member countries of the WHO. Both these agreements promote primary health care or preventive health care.

obligations. WHO would support these sort of activities." (B-P).

7.5 The countries which influence New Zealand health policies

Interviewees named several countries which tended to provide models for New Zealand health policies. A major pre-requisite, however, was the existence of a Welfare State. One interviewee commented ".....we are still a very socialised health care system. We tend to look more to the UK; Scotland more than England. We've also looked at the Nordics although language is a problem here. Canada is another place we look to." (B-P). Another interviewee stated "I think we've tended to grab bits and pieces from different aspects of policy of interest. We don't really look holus bolus at any one country and that's good." (B-P).

Other countries mentioned as influencing New Zealand health policies were, Victoria in Australia, British Columbia in Canada and Scandinavia. One interviewee stated "Victoria, Australia.....British Columbia. British programmes. Scandinavia." (EG-P). Another interviewee commented ".....tend to be influenced by what happens in Great Britain." (EG-P). Another interviewee remarked "I think the changes in Britain are very interesting." (EG-P).

7.6 The media in New Zealand

The media displayed an interest in the Cartwright Inquiry and the subsequent report published in July 1988. The controversy at National Women's Hospital in Auckland provided the media with a sensational and emotive issue which held great public interest.

There were many media publications about the Cartwright Inquiry itself and subsequently with the implementation of Cartwright's recommendations. The newspapers, magazines and nursing and medical journals carried articles about cervical screening, research ethics and patient advocacy. A library search of media articles associated with cervical cancer and the NCSP, covering the period August 1988 to September 1990 found twenty articles. Another library search of newspapers from May 1990 to February 1992 found seventy-nine printed media articles related to cervical screening (Appendix V). While this is not a definitive list of articles, the relatively large number of articles from these searches tends to demonstrate that the interest in both cervical cancer and the NCSP has been consistent over a period of time.

The Minister of Health noted the media interest on at least one occasion. On 10 April 1989, she wrote to the Director-General of Health requesting an explanation of a media report about the non-appointment of a national co-ordinator for the NCSP (Minister of Health April 1989).

Because of the impact that the media had on both the public and the politicians, it could be said to be a powerful source of political pressure. The media, therefore, can legitimate issues of concern. In the case of the NCSP policy, the number of articles published by the media could have played a role in ensuring that the notion of a NCSP became a legitimate concern for the public and the government.

7.7 Summary

The successful cervical screening programmes overseas had influenced the development of the NCSP policy, according to interviewees. The NCSP policy-makers had tended to look to the successful countries, particularly those with a welfare

state, as a base for New Zealand's cervical screening programme. Two interviewees pointed out that transporting policies from one country to another could be risky as the social contexts were never the same.

The international women's movement appeared to influence the NCSP policy as it focused attention on women's health. New Zealand has links with the WHO which have influenced the NCSP policy. The Alma Ata Declaration and the Ottawa Charter have placed New Zealand under a moral obligation to focus on primary health care.

The media in New Zealand has shown a consistent interest in cervical screening since the publication of the Metro article in 1987. The Minister of Health was influenced to act by media interest on at least one occasion. Thus media interest may play a role in influencing the community to identify issues as requiring legitimate consideration.

This chapter has focused on the environmental factors which influenced the development of the NCSP policy. The next chapter presents the interviewees' more personal factors which influenced the NCSP policy development.

CHAPTER EIGHT

THE PERSONAL FACTORS AFFECTING THE NCSP POLICY

8.1 Introduction

This chapter presents interviewees' more personal factors which may have impinged on the policy-making process. The more personal factors relate to interviewees' perceptions and opinions about: the forms of expertise found within the Expert Group, interviewees own personal aims and objectives, the overall problems encountered in the policy-making process, the overall advantages of the NCSP policy-making process and the changes that interviewees would make if they had to develop the policy again.

8.2 The forms of expertise within the Expert Group

The interviewees identified a variety of expertise within the Expert Group. One interviewee states that there was a variety of expertise within the Expert Group including "The medical people, the nurses, the lab, the O&Gs (obstetricians and gynaecologists), the Family Planning Association, the Cancer Society, epidemiological expertise and the woman's voice." (EG-C). Another interviewee commented

The persons themselves and their knowledge about people as well as their own fields of technical expertise. We had Peggy with her sociological background and familiarity with developing policy. There was expertise from a cytopathologist, Maori women, Pacific Island women, consumer representatives (Pakeha), health education, Women's Affairs, nurses' perspective, GP perspective, epidemiological perspective, Family Planning perspective, and the O&G area that was really quite lacking due to underrepresentation. (EG-P).

The Expert Group's expertise identified by interviewees could be broadly categorised into two factions. There was the professional or technical faction and the consumer faction. As one interviewee stated "It seemed to me that there were two groups. There were those who were trying to make the programme work and those who didn't have the requisite knowledge to do so." (EG-P). A second interviewee maintained "Some had no experience of policy development and it showed." (EG-P). A third interviewee stated "Technical i.e. professional, consumer and policy (forms of expertise)." (EG-P). A fourth interviewee remarked "Broadly the Expert Group represented consumer and professional interests." (B-P). A fifth interviewee described one faction within the Expert Group as "..professional people representing professional technique.." while the other faction represented "..a particular ideology." (EG-P). A sixth interviewee identified the expertise within the Expert Group as "The medical people, the nurses, the lab, the O&Gs, FPA, the Cancer Society, epidemiological expertise and the woman's voice." (EG-C). A seventh interviewee identified the expertise within the Expert Group as "...the laboratory people,...the Ministry people,...people coming from the women's lobby, Maori women, Pacific Island people, Cancer Society..." (EG-C).

8.3 The major aims of interviewees

The major aim of all interviewees, in the development of the NCSP policy, was the development of workable policy which would ultimately result in a lower mortality rate for cervical cancer. One interviewee commented "To get the jolly thing working. I saw that if I could help others to see that they needed to do this (have a cervical smear) for everybody's sake that it would be very important." (EG-C). Another interviewee stated "To see that the programme worked and to reduce the deaths from cervical cancer as a

primary goal. Secondly to see that people were taken on board about it so that in the future there wasn't the potential for it to be sabotaged. Thirdly to be as cost-effective as possible." (EG-C). Another interviewee aimed "To get a good smear-taking service to women so that the mortality would go down." (EG-P).

The NCSP policy would have to be economically responsible and viable and able to be effectively implemented. One interviewee maintained that the aim was "To make sure that we have a robust policy that would be economic of resources and effective in its implementation." (B-P). Another interviewee aimed "To ensure that the policy was implemented effectively for women and that it got going and got going in such a way that it was acceptable and available for all women." (EG-P).

8.4 The overall problems encountered in the development of the NCSP policy

Interviewees identified three significant problems which interfered with the policy-making process. These were the political uncertainty about the future of the NCSP policy, the difficult relationship between the Minister of Health, the Expert Group and the Department of Health and the lack of planning undertaken by the Department of Health and the Minister of Health's office. One professional's viewpoint about the problems encountered in the policy development process related to the political uncertainty. This interviewee commented "Overall the problems relate to the uncertainty - the most difficult thing to live with." (EG-P).

The breakdown in communication between the Department of Health, the Expert Group and the Minister of Health was identified by several interviewees as a problem. One interviewee stated

The major problem was the breakdown in communication between the Minister and the Department. To some extent also a breakdown in communication between the Department and the Expert Group. There was a problem in so far as the players had no clear purpose which meant that some of the players moulded out their own purpose which was not necessarily appropriate and I refer to middle management in the Department. Also the Minister. And it would also be individual members of the Expert Group. The purpose was not clear. (EG-P).

Another interviewee remarked "The difficulty was that there was little support for the group from the Department. It was slow in getting the information that we required on which to make decisions. ...also it wasn't clear whether we were getting political support from the Government as well." (EG-C).

The complexity of a national programme which required a multidimensional approach was mentioned by some interviewees as problematic in the development of the NCSP policy. One interviewee stated "There was a complex set of issues." (B-P). Another interviewee commented "..(tendency to) underestimate the enormous task.... we were establishing a nationwide programme with extremely limited resources..." (B-P).

A further problem related to the Department of Health was the lack of planning on the part of the Department of Health and the Minister of Health's office. The setting of goals and targets by the Minister's office was criticised by one interviewee who stated "The NRB type survey of a national representative group of women should have been done before the goals and targets were set. It would have helped to know the size of the problem and may have allowed more creative solutions e.g. free smears to women who hadn't had one in the previous three years." (EG-P). Another interviewee commented "We didn't know where we were so there was no way of setting goals as to where we should be moving or what we should be achieving. We didn't know how many women were being screened. We didn't know the age

group of women most at risk or where we should be focusing our efforts." (EG-P). A third interviewee maintained "...we didn't conceptualise the whole thing strategically as well as we might have. We worked hard on some things and not on others. Then people started to get critical. One of the problems with policy development is that your implementation starts with policy-making. I think if we had sat down and taken a more planned approach we would have better dealt with the various elements in the strategy." (B-P).

Another interviewee commented on the Department's attitude to the NCSP policy. This interviewee stated "It was....slow and I just think it was too big for the Health Department.it was not really something that the Department wanted to do. It seemed to me that the Department's idea in general was to devolve its problems down to the area health boards and I think that was always the problem." (B-P).

A consumer representative described a problem encountered in the policy development process as the unrealistic raising of consumer expectations. She commented

One of the problems was that the Health Department barged in and did a whole lot of daft things early in the piece which have now become part of women's expectations about cervical screening. You start taking those things back and women think they're being deprived of something. That is a problem that I see the programme having. (EG-C).

The outcome of the poor relationship between the Expert Group and the Department was that the bureaucrats did not have their usual input into this particular policy. In fact the policy statement produced by the Expert Group in August 1990 (National Cervical Screening Programme: Policy Statement of the National Cervical Screening Programme Expert Group) had almost no input from the Department of Health (personal observation) apart from the provision of research documents.

8.5 The overall advantages of the NCSP policy-making process

In spite of the problems identified by interviewees as impinging on the policy-making process, the majority of them maintained that there were significant advantages in having a group of professionals and consumers develop policy. One interviewee stated "A lot of insights into how to make it acceptable to women....To bring all the points of view and to debate them." (EG-P). Another interviewee commented

I believe that we came up with something that had the potential to work, to be acceptable to women and having consumer people there means that people have more trust in it. They're not going to criticise it when they've been part of the development of it. ...a very good consensus process.... The labs were made to brush themselves up to speed for accreditation purposes. (EG-C).

One interviewee maintained that the NCSP policy was advantaged by having significant consumer input. This interviewee stated

The advantages were that the policy certainly reflected consumer input. Health Department policy tends to be top-down, 'You will do this' type of approach, whereas I felt that it had certainly come from the needs of women. 'We want the smear, we want the service for us.' It wasn't an idea like it would be a good idea to stop people smoking. I'm sure smokers wouldn't want that sort of top-down approach. I said it was a grass roots policy. That was one of the big advantages. It was owned by a lot of people even before it got off the ground. (EG-C).

The utilisation of a wide range of views and expertise was described as enabling the production of a comprehensive and potentially acceptable policy. One interviewee commented "We got a wide range of views. ...these views are all taken into account in the policy which should be well used." (EG-P). Another interviewee maintained "The idea of

having the expertise all in the one place was a very effective way of operating." (EG-P). A third interviewee remarked "...various pressure groups were brought together and had to design something. It worked a lot better than I thought it would." (EG-P).

The process of using a group comprising consumer and technical expertise to develop policy was supported by the majority of interviewees. The large size of the group did not facilitate the policy-making process but after some sort of rapport was built up by group members, the group focused on the task at hand. One interviewee stated "In the end we did achieve a rapport. I'd quite like to see that group get together on an annual basis or something, just to look at policy." (EG-P) Another interviewee commented "It was a charged sort of group. There were a lot of interests and a lot of lobbying. There was a core group...There was a bit of suspicion about what was going on in the group at times. ...it was an opportunity to work with a group of very interesting people, with a very important aim." (EG-P).

Using a large group to develop policy is more time-consuming but the end product is probably more acceptable to policy implementers and consumers. One interviewee stated "...was a very big group and we certainly had problems with that. ..didn't function particularly well....fair hearing of everybody...difficult to get a word in edgeways...good deal of debate.." (EG-P). Another interviewee commented "...big but good, too slow....covered the same ground over and over again...pleasant group to work with...too disassociated from the Minister...frustrating." (EG-P).

According to interviewees there were overall advantages in the policy-making process utilised in the development of the NCSP policy which tended to compensate for some of the disadvantages. While some interviewees maintained that the

policy-making process was difficult at times, the whole NCSP policy experience did not put one professional interviewee off policy development in the future. When asked whether she would participate again in another policy-making project one interviewee stated "I suppose I'd say yes....I do feel I had something to offer. I had got to the stage where I didn't exactly look forward to the meetings!" (EG-P).

8.6 The changes that interviewees would make if they had to develop the policy again

Some interviewees stated that, in any future policy-making group, they would require to know exactly what the terms of reference were and the length of time given for the achievement of these. One interviewee stated "I would want much clearer parameters about where the Department wanted to go and the Minister wanted to go." (EG-P). Another interviewee would require a "Clearer idea of the exact role of the Group." (EG-P). Another interviewee would request more time and commented "...making sure that there is not so much pressure put on people. ...put in slots to evaluate where we are going and make more provision for that" (EG-C). Another interviewee noted "It would have been better to have had more time to do it. It would have been good to have presented the policy to women's groups so that they felt that it was something for them. It could have been circulated more widely." (EG-C).

One interviewee suggested that consistency of both committee membership and officiating Departmental officers could have helped. The interviewee commented "...more discussion would have helped. It was messy having a chairperson for two meetings and then another chairperson for the rest. It was messy having a change of support staff in the Department. Would have been happier to have been clearer about what our function was, how long we were

to last and what support mechanisms we could rely on and use." (EG-P).

One interviewee stated that a smaller policy-making group may have worked a lot faster and several interviewees stated that Departmental support was important. One interviewee stated "Fewer on the Group. Departmental support and clearer authority." (EG-P). Another interviewee remarked

I would get commitment and direction established clearly from the Minister of Health. ...ensure that the Department was fully behind it. ...link up budget information with policy decisions. ...included a PR person on the Expert Group. ...established proper pilot projects with defined hypotheses and measurable outcomes. (EG-P).

The support of the Minister and the Department concerned needed to be transparent to any policy-making group. It would be important to work with the Department and not against it. As one interviewee stated

Clearly I would want the relationship of the Expert Group and the Minister of Health and the Department of Health much clearer. I would want to be briefed much better, initially and I would want regular meetings with the appropriate Departmental staff. I would want much clearer parameters about where the Department wanted to go and the Minister wanted to go. (EG-P).

A minority of interviewees made the point that the need for a NCSP should have been well researched and evaluated prior to any decision to develop a NCSP. The political fall-out from the Cartwright Inquiry caused problems for the policy-makers. As one interviewee stated

Basically it was a double-edged sword, the National Women's Inquiry (the Cartwright Inquiry). It catapulted the issue of cervical screening forward. It provided the argument in support of a programme. It got things moving in a way that we never could have. At the same time, the fact that it then became a political issue meant that it was very important to move it along quickly without the proper groundwork being done. As a result the people who were given the responsibility for the programme originally, in all fairness to them, weren't able to consult, had to put

on blinkers because of the requirements to get it going fast. All this has made the whole process incredibly difficult and expensive. To me that's really sad but it's all the more reason why we can't give up. (EG-P).

Another interviewee maintained

The programme went for the big one first. Cartwright anticipated a particular end-point without researching it first. The Department of Health was not asked for a detailed report. It should have been trialled and piloted rather than fast-tracked. Cartwright provided the solution. The Department of Health couldn't or wouldn't reflect on her recommendation. The Department was landed with a one-off, big-time, expensive option. We will never be able to cost it out and evaluate it. (B-P).

It appeared that the Labour Government was committed to implementing the recommendations which were to come out of the Cartwright Inquiry without evaluating these further. The decision to develop policy for the establishment of a NCSP was made by the Labour Government. The Department of Health had no opportunity to evaluate the need for a NCSP. The political decision to adopt Cartwright's recommendation about the establishment of a NCSP was undoubtedly the reason that the programme exists to date.

8.7 Summary

The more personal factors included the personal opinions and perspectives of interviewees. The interviewees identified a variety of expertise within the Expert Group which could be broadly categorised as technical or professional and consumer. The major aim of interviewees was broadly congruent and aimed to ultimately reduce the mortality rate associated with cervical cancer. Interviewees maintained that success in reducing the mortality rate would require the development of an effective policy that was acceptable to women and that was economically viable.

The problems which interviewees encountered during the development of the NCSP policy were: the political uncertainty of the NCSP policy, the difficult relationship between the Minister of Health, the Expert Group and the Department of Health and the lack of planning undertaken by the Department of Health and the Minister of Health's office. It appeared to interviewees that the Department of Health had underestimated the complexity of the NCSP.

Interviewees saw significant advantages in using a group of professionals and consumers to develop policy. Having the input of different points of view and being able to debate these was seen as positive. In addition, including the community in the development of policy results in more trust of the policy and less criticism of it. If interviewees had to develop the policy again they would seek clear terms of reference and the associated proposed timelines. Having a smaller policy-making group and ensuring that the group had the support of the Department of Health and the Minister of Health was something many interviewees would want to ensure. A minority of interviewees would require an evaluation to be made of the need for a NCSP prior to any decision to adopt a NCSP as policy.

This chapter has focused on the personal opinions and views of interviewees about the NCSP policy development process. The next chapter focuses on the notion of community participation in the development of social policies.

CHAPTER NINE

CONSUMER PARTICIPATION IN THE NCSP POLICY-MAKING

9.1 Introduction

This chapter focuses on the concept of community participation in policy-making, particularly in the development of the NCSP policy. The political ideology of the 1980s encouraged community participation in policy-making. Community participants in the form of consumer representatives were thought to make an important contribution to the development of the social policies in general according to some interviewees.

Interviewees' opinions about the degree of consumer input into the NCSP policy are discussed together with the issue of representativeness of consumers. The selection of consumer representatives and the policy-making skills that they require were discussed by interviewees and reported here.

In policy-making groups it is important that the aims and objectives of consumer and professional policy-makers are not too diverse. The aims and objectives of the NCSP policy-makers are described and both professionals and consumers gave their impressions of the way that consumer representation worked in the Expert Group.

9.2 Community participation: the political perspective

The corporatist elements of the Labour Government supported the participation of community members in the development of policy. In the case of the NCSP policy, this resulted in consumer participation. Representative consumers were appointed by the Minister of Health and joined with

professionals in developing the NCSP policy. Interviewees reported that the political ideology at the time of the NCSP policy development was supportive of community participation. Political support for community participation in policy development was discussed in Chapter Six.

The Health Care System in New Zealand is strongly dominated by the state and the medical profession. So in the receipt of services, it is difficult for consumers to "vote with their feet" resulting in a relative sense of powerlessness (Richardson 1983). By including consumers with providers in the development of policy, there is a theoretical balancing of the power relations between consumers and providers (Richardson 1983). In the health field consumers should theoretically be enabled to counter, at least to a degree, the dominance of the medical profession (Brown 1975).

9.3 Consumer contribution to policy development: Important or not?

Interviewees were unanimous in their view that consumers should have input into the development of policy. They maintained that consumers should be intimately and consistently involved with the development of social policies. One interviewee maintained "...they're absolutely vital.to make sure that policies work and are accepted. ...to make sure that policies are effective." (EG-C). This view supports Parker's (1975) notion that consumers should be the judge of their own interests. Another interviewee stated "...policy will be more realistic and valuable if consumers are consulted." (EG-P).

One interviewee maintained that consumer involvement in policy-making was important in order to avoid top-down

policies. This interviewee stated "It's very important to have consumers there because it becomes a top-down professional policy, if not." (EG-P). This statement suggests that top-down policies reflect the needs of bureaucrats and conversely bottom-up policies reflect the needs of consumers. This supports Richardson's (1983) contention that consumers perceive top-down policies as reflecting bureaucrats' needs not consumers needs.

On the issue of the desirability or otherwise of consumer participation in policy-making another interviewee maintained that while consumer involvement in policy-making was not easy "...the fact is if you don't involve consumers at an early stage it could be disastrous when you go to implement the policy." (EG-P).

The consensus opinion of interviewees, therefore, was that consumer input into policy-making was important particularly for acceptability of policies and to ensure effective policy implementation. As one interviewee stated "Theirs (consumers) is a dimension which must always be taken into account. They must be represented in some form." (B-P). The unanimous opinion of interviewees was that consumer input into policy-making is highly desirable.

9.4 The amount of consumer input into the NCSP policy

Some interviewees, including all the consumer representatives, thought that there was a significant degree of consumer input into this policy. One interviewee stated "Yes...It (consumer input into the NCSP policy) was quite strong." (EG-P). Another interviewee maintained "In terms of the people who came from the women's health movement....their input was magnificent." (B-P). Another interviewee commented "There was consumer input into the development and writing of the policy." (EG-P). A third interviewee remarked "Yes I think there was." (EG-C).

Another interviewee noted "...yes I think they did make an input." (EG-C).

Other professional interviewees were less certain about the degree of consumer input into the NCSP policy. One interviewee commented "Some people would say yes there was and some people would say there was not enough. Basically I think there was but it is a very problematic area." (EG-P). This opinion was supported by the following interviewee who commented "Not as much as I would have liked. The input was variable around the country." (EG-P). When asked whether consumers were involved with the development of the NCSP policy one interviewee remarked "Yes and no. I suspect that the answer is no." (EG-P). Another interviewee stated "...there was considerable claim to a good deal of consumer input into this policy. Whether it did or it didn't, I'm not in a position to say." (B-P).

On the question of the degree of consumer input vis a vis professional input into policy-making interviewees thought that consumers should have the same degree of input as professionals. One interviewee stated "Their (consumers) expectations must be put on the table and prioritised along with everyone else's. It doesn't necessarily mean that they get carte blanche over everyone else. Everybody who has legitimate expectations should be heard." (B-P). This statement supports the view that consumers have the right to participate in policy-making which in turn expresses faith in the dignity and worth of consumer participants (Richardson 1983). Another interviewee supported consumer participation and commented "I think it is very important to have a consumer voice in early in the development of social policy." (EG-P).

Some interviewees expressed concern that the professionals did not appear to have as great an input into the NCSP policy development as the consumers. One interviewee made the following statement "I think the question is also which

groups were not heard. I would have to say the doctors...the medical profession. That worries me." (EG-P). Another interviewee commented "The Group seemed to be dominated by consumers so that it was occasionally a problem to get the professional view across." (EG-C). This last comment is particularly interesting as it was made by a consumer representative. Thus the view that the professionals were not particularly well heard in the Expert Group was shared by both professionals and a consumer representative.

So some interviewees thought that there was a degree of consumer input into the development of the NCSP policy. Other interviewees maintained that the policy could have benefited from more consumer input. The perceived larger degree of consumer input relative to the professional input was a matter of concern for some interviewees. The claimed larger degree of consumer input into the NCSP policy supports the view that by participating in policy-making consumers have more influence over policy decisions (Richardson 1983). This view is supported also by the disquiet expressed by some professionals over the perceived smaller amount of professional input into the NCSP policy and tends to suggest that the professionals did not dominate the consumers in the NCSP policy-making group (Richardson 1983).

9.5 Consumer representation

The issue of the representativeness of consumers involved in social policy development was of concern to some interviewees who pointed out the complexity of this issue. The difficulty of obtaining true consumer representation was not easily solved. One interviewee's opinion was that the selection of consumer representatives should be an exercise in compromise and the best person should be chosen. The interviewee stated

You're looking for the perfect person (consumer representative) and it's not possible. You can go to either end of the continuum. You agree that some women are so well educated and so multidimensional that they can represent everybody's point of view, superperson, or everybody's so different that no-one can represent anybody else. The truth is a compromise. Either way you're caught. So you take the best person. I mean, why don't we agree also that one economist doesn't represent the economic profession either? It's the same problem. We don't seem to have recognised that there are different community views. There are different Maori views. We don't recognise that for political reasons. I don't have too much of a hang-up on that. (EG-P).

The requirement to select or appoint consumer representatives who truly represented consumers was described as important by interviewees. One interviewee suggested a method of obtaining consumer representatives for policy-making groups could be to approach regional women's groups. The interviewee maintained "...they (consumer representatives) must be representative and not hand picked people because that is an important principle to consumer people and also I believe it is the way to get the best people for the job." (EG-C). In the case of the NCSP policy, consumer representatives were recruited from regional groups. She stated "...there were no national groups you could go to.....So those groups (regional as opposed to national) were approached and came up with a representative." (EG-C).

Another consumer representative supported the use of regional as opposed to national women's groups as a source of consumer representatives. She maintained

We (woman's group) actually received quite a bit of support from the community. There was a push then for consumer representation which came really from a whole push from Labour anyway which is part of the whole policy of community involvement, community participation. Returning back to that kind of thing. I think our involvement was the recognition of our interest and our concern, our experience. So we weren't plucked by accident. I think we were chosen quite carefully because of our long involvement. (EG-C).

The most useful consumer representative would be a person who had substantive skills in the specific area under discussion as well as policy-making skills. One professional interviewee maintained that it would be difficult to find such skilled people within women's groups. The professional representative commented

I think you need a variety of expertise to be that sort of (skilled consumer representative) person. You need expertise of the substantive area, be it Maori women or nursing or whatever. You need to know your stuff. You also need to be a person who can work with other views, many of them opposing, and not get het up. You have to keep your cool. You also need to be a person who understands group process and understands that in seven out of ten times you probably won't get what you want, but three out of ten is a reasonable score. If you go to a group of women or people, you are only looking for somebody who has a good substantive knowledge and not necessarily all the other things. (EG-P).

It would seem, then, that the skills required by consumers involved in policy development are considerable. Not only do they need to be knowledgeable about the substantive area, they need also to know a great deal about the policy development process.

The lack of policy-making skills exhibited by some consumer representatives affected the functioning of the Expert Group, according to one interviewee, which resulted in problems for the group as a whole. One interviewee commented

I think it is unfair for (individuals) to be put on a committee where they are pitted against other people who have a much better understanding of the political process. If you are going to appoint ... people they should be politically astute. They should know their stuff and they should know the committee process. If they've got the first but not the second they should be given information about how the committee process goes. (EG-P).

The acquisition of knowledge in policy development itself would undoubtedly alter the perspective of consumers and

make them less representative of the "woman in the street", in this case. One consumer representative was in no doubt. She stated "I'm sure there is some distancing ... I think that is inevitable as you become more skilled in the area you're in." (EG-C). This statement supports the contention that consumer participants become unrepresentative through their participation (Richardson 1983). Any consumers with the requisite expertise in policy development would be few and far between and could well be constantly called on to advise on policy. Such a situation would be paradoxical and result in experienced consumer policy-makers. This elite group of consumer policy-makers would not necessarily be representative of the 'person in the street'. However, the ideal theoretical position hardly ever exists in practice. Therefore, compromises have to be made.

The view that consumer representatives involved with developing policy require substantive and policy-making skills tends to support the notion of an elite group of policy-makers in society (Hill 1982). The technocratic view is that "experts" opinions carry greater weight than others (Hill 1982). The logical outcome of this view is that policy-making decisions become the exclusive prerogative of the traditional professional policy-makers in society.

9.6 How consumer representation worked

Consumer participation in the policy-making process does not have universal support because it is thought that this is a time-consuming method of policy development (Richardson 1983). The consumer representatives on the Expert Group maintained that consumer representation worked extremely well for them. One interviewee commented "I think it (consumer representation) worked really well. ...the whole group (Expert Group) was committed to cervical screening. That made for easy working." (EG-C). Consumer

representatives reported back to their constituent groups and consulted them on many significant and possibly contentious issues.

One consumer representative described the way that consumer representation worked in her case. She stated

We were told that we should confine our areas of accountability to our particular group. This was difficult because there was no way we could have done more without funding to do so. That's not normally the way I would have worked. I would have brought in a wider group of women. Some women's groups complained that they didn't know what was going on. I was annoyed about that because if I had been able to do what I wanted, it wouldn't have happened. My whole thing that I pushed for the (time) that I was there was to bring women on board with the programme and to do that through women's groups because many NZ women belong to a women's group of some description. To me that is the way to reach women to get a national consensus and I regret that that has never happened. (EG-C).

Another consumer representative, however, did consult widely. She stated "We networked and attached into all sorts of people and asking people in the community. We still have a lot of people to talk to." (EG-C). The positive view that consumer representatives held about their involvement in the NCSP policy-making suggests that they were satisfied with the outcome. This satisfaction in turn implies confidence in the decisions made and tends to enhance one's self-esteem. Thus participation in policy-making can enhance an individual's development and increase self-esteem (Richardson 1983).

The non-consumer representatives had a good impression of the contribution that consumer representatives made to the development of the policy. Several interviewees maintained that the consumer viewpoint was important and brought a different perspective to the policy-making process. One professional representative stated "I think that it worked out very well. I have seen since then what can happen when there isn't a consumer representative and I think the

professionals tend to underestimate the value of consumer input. In terms of the Expert Group, all in all it worked very well." (EG-P). Another professional representative commented "It (consumer representation) seemed to work OK but in patches probably. I don't think everyone will always be happy because on a group like that with many different points of view you get a compromise. I don't know what else we could have done. We certainly didn't ignore the points of view" (EG-P).

While both consumer and professional representatives in the policy-making process identified some problems which were specific to the separate factions, these related mainly to a perception that their own particular view was not as well heard as the other. As one interviewee described it "It is a standard ploy to maintain that, even as a member of a policy-making group, you have had no input. What is usually meant is that people didn't agree with me." (B-P).

9.7 Consumer participation and effects on decision-making

As mentioned earlier in this chapter interviewees viewed the inclusion of consumers in the development of the NCSP policy as important to enhance the quality of the policy decisions so that the programme would be more acceptable to women, the recipients of the service.

The inclusion of consumers to enhance policy-making decisions has prompted Richardson (1983:60) to state "The case for participation is often put with deceptive simplicity. It is necessary to involve consumers in discussions with service providers, it is said, both in order to increase mutual understanding and to achieve better services." The view that participation improves decision outcomes for everyone concerned assumes that the interests of all participants are fundamentally aligned

(Richardson 1983). The discussions in such a group would be characterised by unanimity and a lack of conflict.

According to the Expert Group members, there was conflict within the group. As one interviewee described it "..(the group) had to deal with quite a lot of internal lack of understanding and conflict and a few different points of view." (EG-P). Some Expert Group members maintained that there was more consumer than professional input into the policy.

The perceived lack of professional input into the NCSP policy was a valid concern because the professionals were expected to play a significant role in the implementation of the policy. As Hill (1982) has pointed out, for policies to be successfully implemented governments need the co-operation of policy implementors. The best means of obtaining this co-operation is to involve implementors in the policy-making process (Corson 1986; Child 1984). In the case of the NCSP policy the implementors would be medical and other health professionals whose representatives were members of the Expert Group.

The involvement of both consumers and professionals would be critical in the successful implementation of the NCSP policy and may have been one reason for the appointment of both factions onto the policy-making group. Whether the perceived lack of professional input into the policy will adversely affect the implementation of the policy may become apparent in time. However, the establishment of a causal link between the two variables, lack of professional input and successful implementation of the NCSP policy, would be difficult to ascertain.

The domination of professionals by consumers within the Expert Group implied that the consumer and professional aims and objectives could not have been totally in alignment. In addition, as the consumers were perceived by

interviewees to have had more input into the policy than the professionals, one could conclude that the consumers were more powerful and adept at debate than the professionals (Richardson 1983).

There are a number of factors which affect the relative power of different factions within policy-making groups. These relate to the saliency of the issues for participants, the sharing of beliefs and assumptions, the debating skills of participants and the belief of participants that they can influence the discussions (Richardson 1983).

Both consumers and professionals within the Expert Group did share some common aims. The interviewees in the present study articulated the same aims, essentially to reduce the death rate and incidence associated with cervical cancer and to develop a workable and acceptable policy. One consumer representative described her aim as "To see that the programme worked and to reduce the deaths from cervical cancer" (EG-C). A professional representative described the aim as "To get a good smear-taking service to women so that the mortality would go down." (EG-P). These at least were the overt and technical aims which were mentioned. The similar aims of consumers and professionals would have provided a common background for both factions and a starting place for the negotiation of policy decisions.

There were other aims and objectives which could not have been congruent because there was a degree of conflict within the Expert Group as it developed the policy for the NCSP. Service providers expressed the opinion that the policy-making process was dominated by consumers. There was an expressed opinion that the policy development should have been left to the professionals. One professional stated "... (consumers) can identify problems but they cannot always solve them. This is where professionals come in."

(EG-P). The impression given was that consumers should have some input by discussing their wishes with the professionals who should then be left to develop the policy themselves.

One interviewee maintained that there are difficulties with consumer participation in the policy-making process. The interviewee stated

(Consumers) are consciousness raisers, they are not negotiators. There comes a time when the negotiators need to get on and develop policy. Previously when you just had the dominant professionals developing policy, they very quickly came to the point of agreement. People were prepared to take decisions. You might say that that wasn't very democratic etc. That's true but what they were able to do was to move on. Now there is a cacophony of noise because everybody has to have their say and there is difficulty in reaching a consensus or making a decision and moving on. The trick in the future is how do you take on board all those different points of view and actually move on. (B-P).

Consumer representatives maintained that the NCSP policy should be very acceptable to women because it had a significant amount of consumer input during its development. When asked whether the NCSP policy reflected what women wanted one interviewee stated "I think more than any policy that I have ever seen." (EG-C). The validity of this view may be demonstrated, or not, over time. While the debating skills of policy-makers was not particularly focussed on in this research, the fact that interviewees perceived that there was more consumer input into the NCSP policy might indicate that the consumer representatives were skilled debaters.

Richardson (1983) has defined the main function of a policy-making group which involves both service providers and consumers as that of bargaining. She points out that bargaining entails a clear adversarial relationship while participation connotes a mutual recognition of the common interest. Because bargaining implies a degree of conflict,

it is a more realistic description of the actual workings involved in participation.

All these differing viewpoints are a source of cleavage in policy-making groups. This belies the simplistic notion that the distribution of power in decision-making groups is obvious or attributable to certain factions e.g. service providers or professionals. As Richardson (1983:81) has stated

It cannot be assumed that either all consumers or all decision-makers hold a single agreed position on every issue. Consumers and decision-makers, then, generally have some conflicting and some congruent interests which will be reflected in their joint discussions about policy. They confront each other neither as simple adversaries nor as friendly colleagues but as some combination of the two.

The participation of consumer representatives in policy-making does not have predictable consequences (Richardson 1983). While there appeared to be a perception that the consumer participants in the Expert Group dominated the decision-making at the expense of the professionals it is still too difficult to determine whose interests have best been served. This is particularly so as the representativeness of consumers is so problematic. The appointment of consumer representatives to develop policy for the NCSP may have been motivated by the desire to both socialise the consumer representatives into acceptance of and to legitimate the Government's policies.

9.8 Summary

Consumer participation in the NCSP policy-making was facilitated by the corporatist tendencies of the Labour Government of 1987. The NCSP policy-making group, the Expert Group comprised both professionals and consumers. The interviewees maintained that consumer input into policy-making was important to ensure relevance and

acceptability to consumers. Several interviewees were of the opinion that the degree of consumer input into the NCSP policy was significant while others were less certain.

The issue of consumer representativeness was problematic with one interviewee maintaining that the ideal consumer representative does not exist. Consumer representatives require substantive skills in the area under discussion and policy-making skills which tends to suggest rather elitist individuals. Where one should seek consumer representatives for policy-making groups provided two different points of view. One view was that regional groups should be approached for nominations while another view was that regional groups would not necessarily have the people with the skills. The acquisition of policy-making skills may well create some distance between the representative and the "grass-roots" consumers. However, strategies can be developed to ameliorate this problem, to a degree.

The aims and objectives of professionals and consumers within the Expert Group appeared to be reasonably congruent. However, there was a degree of conflict between the consumers and professionals with the outcome that the consumer input appeared to be greater than that of the professional, according to some interviewees.

This chapter has focused on consumer participation in the development of the NCSP policy and concludes the presentation and discussion of some of the factors which influenced the development of the NCSP policy. The next chapter draws together the conclusions that are drawn from this present case study.

CHAPTER TEN

CONCLUSION

This case study has focused on the development of the NCSP policy. The conclusions drawn from this research, therefore, relate specifically to the NCSP policy. The NCSP policy is a social, health policy and the development of social policies occurs in the context of specific political and social systems which impact on and influence these policies. The unique circumstances and political influences which resulted in the adoption by the Government of the NCSP policy have been described in earlier chapters. There are several conclusions which may be drawn from the information in the earlier chapters and these will be made in this chapter.

Since the research involved public and social policy development it may be helpful to reiterate the main features of such policies. Public policies are decisions made by those in power, that is the government (Leichter 1979), on behalf of society as a whole (Hill & Bramley 1986). The study of policies, therefore, necessarily involves a description of the causes and consequences of government action (Dye 1976 Cited in Hill & Bramley 1986; Ham & Hill 1984). This study of the development of the NCSP policy is no exception; government actions were described and possible explanations of the causes of these actions given in earlier chapters.

The NCSP policy is a social health policy designed to reduce the incidence and mortality associated with cervical cancer. The NCSP policy is, therefore, a social policy in which the state has made a decision which relates to society as a whole (Hill & Bramley 1986). This implies

collective community involvement as opposed to the private concerns of individuals and groups. Collective community involvement does not fit with the individualism espoused by Treasury (1987) and evident within the language of the market place. So there is a paradox in the designing of a social policy for a consumer. The word citizen was advocated by one interviewee and would seem to more appropriately fit with the notion of a social policy.

The social policy in the NCSP related to the provision of cervical screening services. Cervical screening and early treatment of any cervical abnormality is an accepted health check for well women which aims to reduce the morbidity and mortality associated with cervical cancer. Cervical screening is a personal health service offered to individual women.

In the early 1960s in New Zealand there was an interest in offering cervical screening on a population-wide basis. It was thought that a population-wide cervical screening programme would more successfully lower the morbidity and mortality associated with cervical cancer than personal cervical screening would. Thus population-wide cervical screening was trialled in the North Island in the 1960s.

These cervical screening trials were not strongly supported because the efficacy of cervical screening itself was being questioned. Professor Green of National Women's Hospital in Auckland was promulgating his theory that severely abnormal cervical cells did not necessarily progress to become malignant or cancerous. Green conducted his own research on women with severe cervical abnormalities and observed them over time without performing any kind of prophylactic treatment. Green's theory was in direct opposition to the consensus opinion amongst the majority of the world's experts in this area, who advocated early treatment of abnormalities. Green's research was severely criticised for being unethical as his female subjects were

unaware either of their conditions or of their involvement in research.

The controversial research at National Women's Hospital in Auckland was brought to the attention of the public by Sandra Coney and Phillida Bunkle who co-authored an article detailing the events surrounding the research. This article was published in Metro magazine in June 1987. The Labour Government's reaction to this was to order a Commission of Inquiry into the allegations concerning research at National Women's Hospital. *The Report of The Cervical Cancer Inquiry* was published in July 1988 and recommended the establishment of a NCSP.

The Cartwright Inquiry was a highly significant event which provided the spur for the establishment of a NCSP. There was no doubt in the minds of those interviewed that the NCSP would not have become a priority for the Government if the Cartwright Inquiry had not proceeded. This highlights the impact that a controversial and sensational event can have on a government leading to the adoption of a particular policy as a priority.

The experimental research at National Women's appeared to be a highly emotive issue for the public. The proceedings at National Women's Hospital were portrayed as barbaric and unethical by the media. The public was outraged and the media kept the issue very much alive by regularly publishing articles in newspapers and magazines (Appendix V). The television media also followed the proceedings at National Women's and news items and other programmes were screened regularly. All the publicity from 1987 to the present has ensured that most of the population is informed about both the occurrences at National Women's Hospital and subsequent plans to establish a NCSP.

There were a number of influential individuals who had spent many years promoting the desirability of a NCSP.

These individuals had had involvement with preventive health measures and women's issues over a number of years. Most had become authoritative debaters about health promotion and the position of women in New Zealand society. Simply because of their expertise in women's health and or cervical cancer many of these individuals had a close involvement with the proceedings into the allegations at National Women's Hospital (Cartwright 1988). The Cartwright Inquiry served to bring many of these people together. After the Cartwright Inquiry was completed, some of the same people continued to work together. These individuals were a powerful influence over the development of the NCSP policy. They stood out both to their peers and the bureaucrats as significant personalities in the development of this policy. According to Hill (1982) there are dominant individuals in social policy development who are found not amongst the bureaucrats but within the community.

Some of the influential individuals in the development of the NCSP policy were affiliated with interest groups such as the Cancer Society, Fertility Action and The Women's Health Collective. These interest groups, not surprisingly, maintained a watching brief over the proceedings at the Cartwright Inquiry (Cartwright 1988). It is unclear whether the individuals had been influenced by the groups or vice versa. If the individuals had influenced the groups and mobilised more support for the development of the policy, then they were indeed powerful individuals. If, on the other hand, the individuals had been influenced by the groups and were merely their spokespeople, then the use by groups of articulate and authoritative individuals to promote the groups' values cannot be underestimated. More research to clarify the relationships between influential personalities and powerful interest groups would be useful.

The Labour Government in 1988 accepted Cartwright's recommendation to establish a NCSP immediately. This swift substantive policy decision was made by the Minister of Health without consulting the Department of Health. Thus the bureaucrats had little input into this substantive policy decision. The fact that substantive policy decisions were normally referred by the politicians to the Department of Health for evaluation suggests that the substantive political policy decision to establish a NCSP was unusual. This unusual situation tends to suggest that the adoption by the Government of the NCSP policy as a priority was motivated by political factors. Since social policies tend to be dependent on the economic base (Hill 1982) they are normally evaluated in terms of effectiveness and efficiency prior to adoption as substantive policy. There was no such economic evaluation made of the need for a NCSP policy; it became substantive policy overnight.

The Labour Government in 1988 was experiencing a crisis of legitimation as employment rose rapidly and the effects of Rogernomics were felt by the community (Easton 1989). During times of crises of legitimation experienced by the state, there is a strong move to devolve responsibility downwards. This devolution tends to absolve the state of responsibility. The periphery, thus, has the responsibility for carrying out substantive policy decisions made by the state. In so doing, the periphery develops procedural policies and is accountable to the community for these. The state, thus makes the substantive policy decisions while maintaining that it has devolved responsibility for policy-making to the periphery. This responsibility, however, relates almost exclusively to procedural policies only¹.

In the case of the NCSP policy, the Government had made the substantive policy decision and expected the Department of

1 Substantive and procedural policies are referred to in Chapter One page 11.

Health to develop procedural policy for the NCSP. The Department of Health, mindful of the principle of devolution was keen to see area health boards develop procedural policies and take responsibility for the NCSP. The Expert Group members on the other hand were strongly of the opinion that the procedural policy decisions should be made at the centre. The substantive NCSP policy decision was made by the Government. This was a top-down policy decision which supports the contention that the NCSP policy was adopted in response to the crisis of legitimation.

New Zealand was described as undergoing a "fiscal crisis" about the time that the NCSP policy was being developed (Treasury 1987). Although the country's economic condition was thought by policy-makers to be rather dismal, this circumstance did not appear to inhibit the NCSP policy-makers. In fact, the economic considerations were not particularly attended to as policy-makers thought that a political decision had been made to fund the NCSP. The fact that economic considerations did not appear to apply in the development of the NCSP policy further supports the suggestion that the NCSP policy was adopted by the Government as a response to a crisis of legitimation.

The Cartwright Inquiry was a significant event which became the focus of media attention. The media attention in turn brought the events surrounding the Cartwright Inquiry to the attention of the public. The Government publicly responded to Cartwright's recommendation to establish a National Cervical Screening Programme by adopting this as substantive policy. This top-down policy decision tends to suggest that it was made in response to a crisis of legitimation rather than on the basis of the effectiveness and efficiency of the policy. This view is supported by the fact that the substantive policy decision was never evaluated prior to its adoption by Government.

The participation of consumers in policy-making is a useful strategy in the amelioration of the state's crisis of legitimation (Richardson 1983). Consumer participation fits with the theme of corporatism which was espoused by some elements of the Labour Government of 1984 and 1987 (Easton 1989).

In the development of the NCSP policy, the consumer participants were a powerful faction within the policy-making group. The research indicated that the consumer participants dominated the professionals/bureaucrats. This is contrary to the notion that consumer participation is a means of social control. Having made that point, it is important to recognise that the degree of influence that the professionals/bureaucrats had on the consumer participants is difficult to assess. It is almost impossible to determine whether the interests of either consumers or professionals have been served in the development of the NCSP policy. As mentioned previously, the issues surrounding consumer participation are numerous and complex (Richardson 1983).

The fact that the consumer participants were perceived as dominant in the policy-making process may have been an unintended outcome. In other words the participation of consumers in the NCSP policy-making process may well have been instigated by the desire to appease the public and to demonstrate the Government's support for corporatism.

The acceptance of the state's policies tends to ameliorate any crisis of legitimation which results in the interests of the state being served. This appears to be the case with the NCSP policy and it is suggested that the interests of the state have best been served in the development of the NCSP policy rather than those of consumers or professionals.

Aside from the issues of consumer participation and the interests of the state, it has become apparent over the last decade or so that consumers are desirous of being involved with policy development (Richardson 1983). This is reflected in the public's desire to be involved in debate surrounding the *Picot Report* (Codd et al 1990) and the more recent debate surrounding the issue of user-pays in health (Minister of Health 1991). There are many issues surrounding consumer participation in policy development which require closer study. One of these is the issue of the representativeness of consumer participants in policy-making. The research showed that, to be effective, consumer participants require considerable skills. Not only do consumer participants require substantive skills in the specific policy under discussion, they also require policy-making skills. The acquisition of policy-making skills requires specialist knowledge and the acquisition of this specialist knowledge alters the status of the consumer participants. It could be argued that consumer participants with such specialist knowledge are by definition professionals and therefore lose their consumer status. Such consumer representatives are, therefore, no longer representative.

There is no doubt that the existence of specialist consumer participants in policy-making connotes elitist policy-makers which is in conflict with the notion of a consumer representative. The choice, however, would seem to be between "true consumer" representatives being consulted by professionals/bureaucrats on an ad hoc basis or the inclusion of specialist consumer participants on an on-going basis.

Consulting with consumer representatives on an ad hoc basis may allow professionals/bureaucrats too much freedom to discard points which they do not agree with. It may be preferable for specialist consumer participants to maintain prolonged input into the policy-making process by sitting

on policy-making groups. Consumer participants would be required to report back to their constituents on a regular basis. If added skills are needed for effective participation in policy development it may behove the community to ensure that their representatives acquire these.

It is recognised that in promoting this idea, there could be an unstated assumption that the policy-making skills defined are right and necessary. This is not necessarily the case. However, until the complex issues surrounding consumer representativeness are clearer, the up-skilling of consumer participants is promoted as a pragmatic interim measure. The requirement that consumer participants report back regularly to their constituents should theoretically serve to ensure wide representation of consumer interests.

In summary this research showed that consumer participation in the development of social policies tended to be viewed as desirable and rightful by participants in the policy-making process. It could then be anticipated that consumer participation in policy-making may become more widespread. This being the case the whole complex issue of consumer participation in policy-making deserves closer study. How consumer participants can effectively contribute to the development of social policies needs to be examined more closely. For example, do consumer participants require specialist skills in order to participate in the development of policy? How does the acquisition of specialist skills affect the representativeness of consumer participants? How can the representativeness of consumer participants be assured? How does one select/find consumer representatives? These puzzling questions would benefit from close study.

The development of the National Cervical Screening Programme policy occurred during a politically turbulent period when the Labour Government was experiencing a crisis

of legitimation. It is concluded that the political substantive decision to give priority to the National Cervical Screening Programme policy was a response to this crisis of legitimation.

EXPERT GROUP MEETING DATES

14 February 1990

29 March 1990

17 May 1990

29 May 1990

15 June 1990

25 July 1990

1 August 1990

13 September 1990

1 November 1990

4 December 1990

1 February 1991

NATIONAL CERVICAL SCREENING PROGRAMME

POLICY STATEMENT OF THE
NATIONAL CERVICAL SCREENING PROGRAMME
EXPERT GROUP

AUGUST 1990

FOREWORD

The Expert Group was established in December 1989. It is charged, amongst other functions, with the responsibility of advising the Minister of Health on national policy and resource allocation for the National Cervical Screening Programme.

The Expert Group includes representatives of medical and health professional groups, consumer groups and the Ministry of Women's Affairs.

The Expert Group's task has been made difficult by the non-existence of a written policy on the National Cervical Cancer Screening Programme. This situation has been compounded by the fact that some aspects of the programme have already been implemented, while others are still undecided.

As a means of clarifying the purpose and process of the National Cervical Screening Programme, this document endeavours to:

- a) document the existing policy of the NCSP
- b) comment on the appropriateness of that policy
- c) set out recommendations for future policy directions
- d) integrate the various elements of the programme into a unified policy package.

In order to set the National Cervical Screening Programme in focus, this document also outlines the rationale for cervical cancer screening and for a nationally co-ordinated programme. It is the Expert Group's view that only with a nationally co-ordinated screening programme will cervical cancer be significantly reduced in New Zealand.

P. G. Koopman-Boyden

Peggy G Koopman-Boyden

Chairperson
National Cervical Screening Programme Expert Group
17 August 1990

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THE NATIONAL CERVICAL SCREENING PROGRAMME - INTRODUCTION

The National Cervical Screening Programme (NCSP) is a public health cancer control programme aimed at saving the lives of New Zealand women and reducing the suffering caused by cervical cancer.

Cervical cancer is one of the ten priority areas contained in the New Zealand Health Goals and Targets. This policy for the NCSP will enable area health boards to meet the goals on cervical cancer set in the Goals and Targets. All the Health Care Principles contained in the New Zealand Health Charter are met by the NCSP. The programme also embodies the strategies promoted in the World Health Organisation's Global Strategy for Health for All by the Year 2000, to which New Zealand is a signatory.

A cervical screening programme is a new concept in New Zealand health care, reflecting the government's focus on preventive strategies. Funding has been provided for the first three years of the programme. To consolidate the gains that will be made in this period, there will be a need for continuing funding for some aspects of the programme. This is a long term strategy, the results of which will not be immediate. Failure to sustain satisfactory screening coverage will mean that the resources invested initially will be wasted.

The programme does not start from scratch, for there is already a high level of screening activity in New Zealand, from smear taking to treatment facilities, as well as considerable public interest. The programme will build on what is already there, aiming to organise the existing components in a coherent way. New facilities will be created only where these are presently absent and their existence vital to the success of the programme.

An organised screening programme will encourage the effective use of resources, unlike the existing ad hoc screening services which are wasteful of resources. The aim will be to offer a service throughout New Zealand which is of a consistently high technical quality and also sustainable over time.

The programme is not a single entity but the integration of various elements. These elements include not only the facilities, such as laboratories and the locations where screening takes place, but also the women who will use the facilities, the personnel who will staff them, and the education programmes which will ensure that New Zealand women are well informed about screening.

A national register will be the key tool in providing the management system for the programme. The register will make sure that women are systematically recalled, that there is a high technical quality of screening, that appropriate action is taken where abnormal smears are detected, and that there is continuing evaluation and monitoring of the programme. To ensure that patients' rights are respected, the confidentiality of personal information held on the register will be protected.

A national policy is important for it sets standards and lays out the responsibilities and relationships, as well as providing strategies for achieving the objectives of the programme. The NCSP policy is based on the experience of successful cervical screening programmes in other countries, with important modifications to suit New Zealand conditions. Responsibility for implementing the policy lies with all those charged with providing health services in New Zealand.

At the national level, a national screening co-ordinator and unit in the Department of Health will provide leadership and support for the area health boards, which are responsible for implementing screening in their areas.

The policy for the NCSP is not proscriptive, but allows freedom for boards to design the strategies most suited to their local needs within broad guidelines. Boards are encouraged to involve women from their communities in all aspects of the planning and implementation of the programme so that women support it. Through public education women will become well informed about the benefits of the screening programme.

Area health boards will work closely with providers in their areas, encouraging the improvement of existing services so that women are invited and encouraged to take part. Equity of access has formed the basis of a number of strategies throughout the programme. Women of all ethnic groups and ages must feel able to participate in screening. A variety of screening services will be provided in board regions, so that women have appropriate choices. The provision of some free and low-cost services will make screening affordable for all women.

In recognition of the principles of the Treaty of Waitangi, special efforts will be made to resource and involve Maori women in the programme and so ensure equity of access for them.

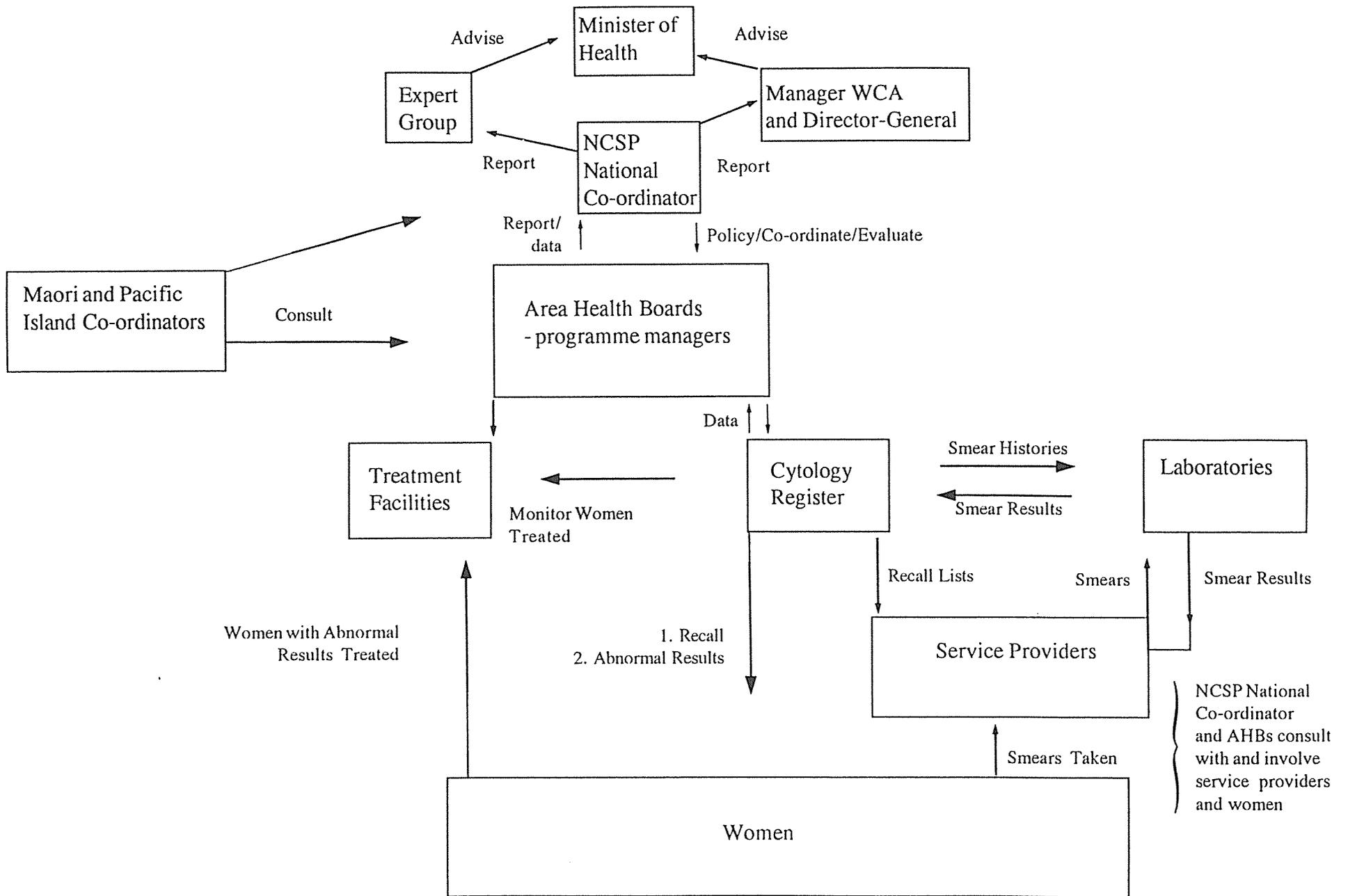


Diagram One: Structure of National Cervical Screening Programme

THE NEED FOR A SCREENING PROGRAMME

1 HISTORY OF THE NATIONAL CERVICAL SCREENING PROGRAMME

1.1 Judge Cartwright's Report

1.1.1 In August 1988 the Report of the Cervical Cancer Inquiry was released. In this report Judge Silvia Cartwright said: "A nationally planned population-based screening programme should be implemented urgently."

1.1.2 Judge Cartwright also recommended the establishment of a group of women health consumers and health professionals "to evaluate procedures, advise on resource allocation and implement" the programme. A director for the programme was, she believed, essential to provide leadership (Cartwright 1988).

1.1.3 The report was adopted by the Government which pledged itself to establish a nationwide screening programme, a possibility which the Department of Health had already been studying.

1.1.4 Following Judge Cartwright's report, the Department of Health took a number of steps towards developing a national screening programme. These included holding a National Cervical Screening Workshop for community representatives and health professionals at Porirua (Report of the National Cervical Screening Workshop 1988); establishing two pilot programmes in the Nelson-Marlborough and Manawatu-Wanganui Area Health Boards; and establishing four community pilot projects for Maori and low-paid women.

1.1.5 In August 1989 the Minister of Health, Helen Clark, announced that specific funding had been allocated for the National Cervical Screening Programme (NCSP) - with a total of \$37.6 million being available over three years. While this announcement was welcomed, there was also criticism of the department's development of the programme from consumer and professional groups (Skegg 1989).

1.2 Review Committee

1.2.1 In September 1989 the Minister of Health established a committee to review the department's plans for the cervical screening programme. The committee's recommendations were accepted by the Minister - its main recommendations were that:

- . the planned national launch date for the NCSP should be cancelled, with area health boards formally joining it only when they had the necessary programme elements in place

- . enrolment in the NCSP should be considered routine once a smear was taken, with provision for women to opt out if they wished
- . Maori screening co-ordinators should be appointed
- . a national co-ordinator should be appointed
- . an "expert group" should be established to oversee the implementation of the NCSP and advise the Minister on policy and modifications to the programme. (Report of the Ministerial Review Committee on Implementation of a National Cervical Screening Programme 1989).

1.2.2 To date, a national screening co-ordinator has been appointed, the Expert Group has been established (its functions are described in section 15), and screening managers have been hired in each of the 14 area health boards.

1.2.3 On the advice of the Expert Group, a National Research Bureau survey was carried out to provide baseline data on screening coverage, and an overseas expert on cervical screening programmes was invited to New Zealand to comment on the plans for the programme so far.

2. PLANNING A SUCCESSFUL SCREENING PROGRAMME

2.1. Incidence and Mortality in New Zealand

2.1.1 Each year over 200 New Zealand women are diagnosed as having cancer of the cervix, and over 100 die from it. Among Maori women, the incidence and mortality is thought to be three times the non-Maori rate (Cox 1989).

2.1.2 In 1987, 117 New Zealand women died of cancer of the cervix. The latest year for which incidence data is available is 1984. In that year, 224 women were diagnosed as having cancer of the cervix. The rates for both mortality and incidence increase with increasing age (Figure 1). Although cervical cancer is increasing in women under 45 years of age, the majority of deaths (75%) still occur in women 45 years and over.

2.1.3 It is now well established that cervical cancer goes through precursor stages which can be detected by cervical screening. This involves testing cells from the cervixes of symptomless women for pre-cancerous abnormalities. If these abnormalities are detected, they can be readily treated. The success rate for adequate treatment of pre-cancers is 98 to 100% (Sharp and Cordiner, 1985). Thus, cervical cancer, unlike most cancers, is largely preventable. Cervical screening has been proven as the major strategy in achieving a significant reduction in the incidence and mortality from cervical cancer.

2.2. Causes of Cervical Cancer and Risk Factors

2.2.1 The causes of cervical cancer are currently uncertain, although a number of factors, relating mainly to the sexual background of the woman and her partner, appear to increase the risk of developing the disease. It has been hypothesised that cervical cancer could be caused by a virus which may be sexually transmitted, and certain types of human papilloma virus have been implicated. Recent research work, however, has cast some doubt on this theory. It is also unconfirmed whether cigarette smoking or long-term oral contraceptive use may also increase the risk of developing cervical cancer.

2.2.2 These risk factors have limited use in planning public health strategies to reduce the incidence of cervical cancer (Hakama 1986). Most women at risk of developing the disease have already been exposed to the causal agent(s) (Cox 1989). In addition, these risk factors are widely distributed in the New Zealand community and are insufficiently precise to define a specific high-risk group.

2.2.3 Previous studies have shown that the most useful indicator of a woman's risk of developing cervical cancer is her screening history (Chamberlain 1986). The women most likely to develop cervical cancer are those who are unlikely to have been regularly screened (McLean et al 1985, Skegg et al 1985). Cervical screening at present provides the only way most women can protect themselves from cervical cancer. This also means that the initial emphasis in any screening programme should be on reaching women who have not been screened.

2.3. Cervical Screening Coverage in New Zealand

2.3.1 Cervical screening in New Zealand is at present passive or "opportunistic", that is, it is unorganised, relying on the enthusiasm or otherwise of individual medical practitioners and the requests of women themselves.

2.3.2 Opportunistic screening usually results in large numbers of smears being repeatedly taken from a limited number of women, and thus low coverage of the population. Attaining a high coverage is important because it is among unscreened women that cancers will occur. An unusual situation, however, has developed in New Zealand. Unprecedented publicity about cervical screening and cervical cancer, firstly, through the Skegg recommendations for routine cervical screening (Skegg et al 1985) and, secondly, through the extensive media attention paid to the Cervical Cancer Inquiry (Cartwright 1988) has led to the recent attainment of a high level of screening coverage.

2.3.3 A national omnibus survey conducted by the National Research Bureau (NRB) in July 1990 demonstrated this high screening coverage (Figure 2). Overall, 77% of women 20-64 years reported having had a smear test in the previous three years. Excluding the women who have had a hysterectomy increased the screening rate to 81%.

2.3.4 The survey also indicated that a high proportion of women are receiving unnecessary smears; 70% of women who had been screened reported having had two or more smear tests done within the previous three years. The mean number of smears was 2.4. This confirms reports from cytology laboratories that very large numbers of smears are taken annually in New Zealand (Jackson 1989, Paul 1990).

2.3.5 Screening coverage, however, is unevenly spread, with Pakeha women being more likely to be screened than Maori women. In the NRB survey, 80% of Pakeha women reported having had a smear test in the past three years compared with 71% of Maori women. No reliable information is available on Pacific Island women.

2.3.6 Screening rates also fell with age. Younger women were more likely to be having regular smears than older women, yet it is known that the majority of cervical cancers are occurring amongst older women. In the NRB survey, women up to 50 years of age reported the highest levels of screening, at around 80%. Women aged 50-54 years had a rate of 63% and women 60-64 years a rate of 50%. In women 65-69 years of age (currently outside the national guidelines for screening) the rate was even lower, at 25%. Sixteen percent of women aged 55 to 69 reported never having had a smear test. These rates for age groups are consistent with previous surveys and reports (NRB 1989, Paul 1990).

2.3.7 As the public attention on cervical cancer wanes, it is unlikely that this relatively high overall level of screening coverage will be sustained. Opportunistic smear taking is largely initiated when women visit general practitioners and family planning clinics for matters relating to reproduction. Consequently, it is unlikely that the younger women now having smear tests will continue to do so as they grow older, when the need for such visits will cease. Therefore, it is likely the death rate amongst older women will persist.

2.3.8 Studies overseas have shown that the risk of invasive cancer in women who cease to be screened after two negative smears progressively increases, reaching the same level as unscreened women after ten years (IARC Working Group on Cervical Cancer Screening 1986).

2.3.9 The introduction of a centrally organised cervical screening programme will sustain the current high rates of screening in New Zealand by retaining women within a regular system of screening. It will also ensure consistency over all age and ethnic groups.

2.4 Future Predictions for New Zealand

2.4.1 In New Zealand, researchers have pointed to the fact that the death rate is rising. The risk of developing cervical cancer has increased very rapidly in cohorts of women born since the 1930s. It has been estimated that a woman born in 1957 may have over three times the risk of dying of cervical cancer than a woman born around 1932 (Cox and Skegg 1986). For these younger women, the incidence of cervical cancer may be as high as 1 in 28. Projections have been made that without an organised screening programme up to 500 women may develop cervical cancer and 150 women die of it each year before the turn of the century (ten years away) (Cox 1989).

2.4.2 If the results of overseas communities with organised programmes are replicated in New Zealand, the NCSP has the potential over a 10-year period to reduce the incidence of cervical cancer by 70% and the number of deaths of New Zealand women by 65% (Cox 1989).

2.5. Screening Programmes Overseas

2.5.1 Experience in countries and communities with organised population-based screening programmes - such as British Columbia in Canada, Aberdeen in Scotland, and the Nordic countries (Sweden, Iceland, Finland and some counties of Denmark) - show the kind of dramatic reductions in cervical cancer incidence and mortality that can be achieved.

2.5.2 In Finland, the reduction in both mortality and incidence from a five-yearly screening programme has been 60-70%. Iceland has shown a similar reduction. In Denmark, Sweden, British Columbia and Aberdeen there has been a moderate to substantial reduction in risk (Hakama and Louhivuori 1988).

2.5.3 In Denmark, screening is devolved regionally to counties. This experience allows comparisons of different screening strategies. Counties with organised screening have achieved double the screening coverage and significant reductions in the death rate compared to regions relying on opportunistic screening. Nationally, Denmark has not achieved the same reduction in incidence and mortality as countries such as Finland (Lynge et al 1989).

2.5.4 The positive impact of organised screening can be seen by the experience of one Danish county which discontinued its screening programme in 1982. While the organised programme was in place, screening coverage of 85% had been achieved. By 1986 this had fallen to 61%, the same level existing in other Danish counties with opportunistic screening. Screening coverage was highest among young women and varied dramatically from district to district. This uneven coverage was accounted for by general practitioners attitudes to screening. It is too early to measure what impact this drop in screening coverage will have on incidence and mortality rates in that county (Jensen and Birch 1990).

2.6 Qualities of Successful Screening Programmes

2.6.1 Studies of successful screening programmes have shown that the reduction in risk is closely correlated with the degree of organisation of the programme. To assist in developing the necessary degree of organisation, effective programmes use computer-based information systems as a

screening programme results in greater quality of life adjusted years saved per unit cost than many other health programmes (Breast Cancer Screening Working Group 1987).

2.8 Why Screening Can Fail

2.8.1 Unlike areas with centralised organised screening programmes, countries such as Australia, New Zealand, England and Wales have made little impact on the incidence and mortality from cervical cancer, despite the fact that large numbers of smears are taken. The failure of screening programmes, such as that in Britain, has been caused by the lack of a central body responsible for screening, inadequate registers, an absence of clear goals and policy, and the failure to increase population coverage.

2.8.2 In Britain, the lack of central direction and adequate management resulted in a fragmented system of 213 NHS programmes, with poor screening coverage and only a slight decline in the mortality rate. The extensive literature documenting this failure concluded that the overriding issues were lack of responsibility and organisation (Bowling and Jacobsen 1989, Lancet 1985, McAlpine 1989, Muir Gray 1989, Muir Gray and Chamberlain 1989).

2.8.3 Screening can also fail because of poor quality in either the smear taking or smear reading. There have been reports of deficiencies in these aspects of screening in parts of New Zealand (Department of Health and the Cancer Society of New Zealand 1986, McCafferty et al 1989).

2.8.4 A failure to follow up women with abnormal results and adequately treat them can also undermine the effectiveness of screening. This was demonstrated by the experience at National Women's Hospital in Auckland where there were delays in treating some women with abnormal smears, resulting in an increase in the incidence of invasive cancer (Cartwright 1988, McIndoe et al 1984). Because of a dearth of information, it is not known whether this failure has been confined to Auckland. One study indicated that delays in treating women had also occurred elsewhere. In a Christchurch study, 14% of women with carcinoma in situ had had a series of abnormal smears, sometimes for up to five years, before being referred for colposcopy (McLean et al 1985).

2.8.5 In an organised programme, the management system can minimise the possibility of such failures by measuring the technical quality of the screening process, and by monitoring the follow-up of women with abnormal smears.

2.8.6 Inadequate back-up treatment facilities, such as insufficient colposcopic services and inexperienced

colposcopists, can also have an adverse impact on a screening programme. Long delays in women gaining access to colposcopy have also been experienced in some parts of New Zealand. Once again, in an organised programme these aspects can be evaluated.

3. THE POLICY OF THE NCSP

3.1 Developing a Policy for New Zealand Conditions

3.1.1 The policy for the NCSP has been developed to ensure that the programme has clear goals, that it is broadly consistent throughout New Zealand, and that its effectiveness can be evaluated and monitored nationally. To reach this policy, the Expert Group has studied successful and unsuccessful screening practices, has brought out an Australian expert on screening programmes to provide an audit of the plans for New Zealand (Straton 1990), and has taken into account aspects of New Zealand society which differ from overseas countries with successful programmes. These differences are both socio-political and related to the delivery of health care services.

3.1.2 Social characteristics of New Zealand:

- . a wide cultural diversity, including Maori, Pacific Island and European
- . a small and highly mobile population spread over a wide area, with significant demographic differences between regions.

3.1.3 Characteristics of New Zealand's health care system:

- . a considerable freedom in obtaining health care - there is no requirement to be registered with a single general practitioner
- . the primary medical care system is a partially-subsidised private one, implying considerable autonomy in the delivery of services by individual practitioners and little direct control by the Department of Health
- . considerable cost to the consumer in gaining access to primary health care services
- . doubt among sections of the medical profession about the efficacy of screening and, as a result, distrust of health-care services on the part of some consumers
- . the absence of any national health registration system to facilitate "call" - the system of inviting women to be screened
- . the existence of an established publicly funded centralised health administration which is actively moving towards a decentralised management structure

- . the failure of health services to adequately address the poor health status of Maori people.
(Adams 1990, Cartwright 1988, Cox 1989, de Boer and Pomare 1988, Seaman and van der Tol 1988).

3.2 Special Features of the NCSP

3.2.1 Because of these characteristics, some elements of the NCSP have been designed specifically to meet New Zealand requirements. These are:

- . special efforts to reach three "priority groups" known to include high numbers of women not being regularly screened: mid-life and older women, Maori women, Pacific Island women
- . the involvement of community groups in all aspects of planning and implementation of the programme, and the provision of resources for them to work on specific projects
- . educational strategies to ensure that women are well informed about screening and the NCSP
- . the provision of choices for women - that is, a range of smear-taking services and smear takers will be available
- . the establishment of some free and/or low-cost services
- . strategies which actively encourage general practitioners to improve the screening service and extend screening coverage
- . consultation with provider organisations to ensure they support the programme
- . freedom for area health boards to devise programmes which will meet the needs of their areas, as long as they are in accord with the national policy
- . strong national guidance and support to area health boards.

3.3 Timeframe for the NCSP

3.3.1 The planning for the NCSP has been taking place for the past two years, and pilot programmes have been run in the Manawatu-Wanganui and Nelson-Marlborough area health boards. In this policy statement the Expert Group has made a number of recommendations for modifications and improvements to the NCSP. In the majority of cases, these modifications could occur while the programme is being implemented. There seems no reason why the NCSP cannot be implemented in other

boards of a similar size to the two boards that conducted the pilot programmes.

3.3.2 There is some merit in the proposal to pilot the programme in a large urban area before implementing it in all large area health boards. Against this suggestion must be measured the impact of further delays. Earlier delays in the implementation of the programme have already caused some loss of credibility.

3.3.3 Area health board screening managers have been appointed in all area health boards, and in many boards considerable planning and community consultation has taken place. A certain momentum has therefore already been engendered. Considerable expertise exists in particular area health boards - Auckland and Wellington are cases in point. It may be unnecessary to put plans in those area on hold. There is also the danger that in other boards idiosyncratic and economically wasteful schemes may be introduced in the absence of national direction.

3.3.4 The Expert Group therefore recommends that the Department of Health makes an urgent assessment of the readiness of individual boards and develops an implementation plan with timeframes for the whole of New Zealand.

3.3.5 It is critical to the success of the NCSP that some aspects of policy be actioned immediately. It is essential that women and provider groups support the programme, and that the strategies for public and professional education and consultation be implemented forthwith.

3.4 Standards for Routine Cervical Screening

3.4.1 A successful, cost-effective screening programme depends on the setting of standards for screening intervals, age groups and categories, and adherence to them.

3.4.2 In 1985 the Department of Health and the Cancer Society established a working party under Professor David Skegg to draft recommendations for cervical screening in New Zealand (Skegg et al 1985). These recommendations stated that:

- . all women who have had sexual intercourse should be offered screening
- . if the first smear is negative, it should be repeated within one year
- . routine screening after the first two negative smears should be repeated at least every three years

- . screening may be stopped at age 65 provided that the woman has had 2 recent negative smears and that no previous smear has been abnormal
- . any woman who has never been screened should have a smear test, even if she is over 65
- . the three-yearly schedule does not apply to women who have had an abnormal smear.

3.4.3 These recommendations are being re-examined in 1990, and extended to provide guidelines on women who have had hysterectomies. Until the results of this reappraisal are available, the Skegg recommendations have formed the basis of national screening policy. For the purposes of the NCSP, it has been necessary to adopt upper and lower age limits. These have been set at 20 years for the lower limit and 65 years at the upper limit.

3.4.4 For the purposes of recall, a three-yearly screening interval has been adopted by the NCSP. Such an interval has been found to be effective in reducing the mortality and incidence from cervical cancer in overseas screening programmes. Moving to an annual programme would prevent about 2% more cancer with no appreciable increase in the prevention of death from cervical cancer compared with a 3-yearly programme. Furthermore, moving from the current estimate of screening activity to a 3-yearly one is between 4 and 5 times cheaper than moving to an annual screening programme (Cox 1989).

OBJECTIVES OF THE NATIONAL CERVICAL SCREENING PROGRAMME

4. THE GOAL AND OBJECTIVES OF THE NCSP

4.1 Goal

4.1.1 The goal of the NCSP is to reduce the incidence of cervical cancer and also its death rate. To achieve this specific objectives have been set for the NCSP, which are based on the New Zealand Health Goals and Targets (1989). The Expert Group recognises that it is difficult to set targets because of a lack of adequate information about cervical cancer and screening coverage. It will be necessary to revise the targets as more information becomes available.

4.2 Objectives

4.2.1 Screening Coverage

Objective 1: by the year 1995, to increase to 80% or more the proportion of all women aged 20 to 64 years who have in the previous 3 years been screened for pre-invasive cancer and provided with appropriate follow-up diagnosis and therapeutic services.

The Expert Group's view is that it will be important to demonstrate that the screening coverage objective is being met in all age groups and for all ethnic groups, and that this continues over time. Information from the July 1990 NRB survey suggests that there are approximately 187,000 women 20-64 years of age in New Zealand who have not had a smear test in the last three years: 150,000 European women, 25,000 Maori and 12,000 Pacific Island women.

4.2.2 Incidence and Mortality

Objective 1: by the year 1995, to reduce the death rate from cervical cancer in women aged 20 to 64 years by 20% or more in Maori and by 10% or more in Pakeha and Pacific Island women; and by the year 2000, to reduce the death rate by 50% or more in Maori and 25% or more in Pakeha and Pacific Island women.

Objective 2: by the year 2000, to reduce the incidence of invasive cancer to fewer than 180 cases annually.

Objective 3: by the year 1995 to increase to 45% or more the percentage of invasive cancer detected at stage 1 of the disease.

*61% already
in 1986*

4.3 Focus of the NCSP

4.3.1 The NCSP should aim to include all women aged between 20 and 65 years. All women should be encouraged to be part of the NCSP and women who are currently having regular smears should continue doing so.

Priority Groups

4.3.2 The initial focus of the programme should be on women who have never had a smear or whose smear history is outdated. Therefore, special efforts and initiatives should be directed at these women first. The Expert Group has also identified three priority groups which will be discussed in detail later in the policy. On the basis of the NRB survey, an estimate has been made of the numbers of women in each of these groups who have never had a smear or whose screening history is out of date:

- . midlife and older women (approximately 145,000 women of all ethnic groups aged between 35 and 65 years)
- . Maori women (approximately 25,000 women)
- . Pacific Island women (approximately 12,000 women).

4.3.3 Women aged 20 to 34 years are more likely to be receiving regular smears. Special efforts, however, are to be directed at women in this age group who have never had a smear or whose smear history is out of date.

4.4 Revising the NCSP's Objectives

4.4.1 In 1984, 224 new cases of cervical cancer were notified. Reliable information about the incidence of cervical cancer is not available for the years after 1984. When up-to-date information becomes available, it may be necessary to revise the objectives of the programme.

4.4.2 When the review of the current recommendations for routine cervical screening is completed, it may be necessary to revise the age guidelines.

A WOMEN-ORIENTED SCREENING SERVICE

5. TAKING ACCOUNT OF WOMEN'S NEEDS

5.1 Planning an Acceptable Service

5.1.1 "When a programme of screening fails to take account of women's needs, expects women to take the initiative in making the appointment, and is organised in a way to suit the convenience of the provider rather than the user, then it is less likely that women will make use of the service" (Eardley et al 1985).

5.1.2 Researchers of cervical screening have emphasised that for a screening programme to succeed, the screening service provided for the taking of smears must be oriented to the needs of users but initiated by providers (Eardley et al 1985, Haran et al 1986). To take part in screening, women must understand that it will benefit their health and feel comfortable about the procedure. They should also be personally invited to take part. Where these conditions have been met, high rates of screening have been achieved and sustained. The existing low screening coverage for some groups of New Zealand women reflects a failure to offer screening in relevant and acceptable ways.

5.1.3 It is essential to the success of the NCSP that the screening service is improved so that women are encouraged to participate. This will involve acknowledging and meeting women's needs and removing any barriers in the way of their participation. A New Zealand study showed that factors which inhibit women taking part in screening can be overcome. Women who were identified as not having been screened said they would take part if screening was offered on a regular basis with a full explanation of the procedure and its purpose in language that they understood (Grace 1985).

5.1.4 Experience in general practice in New Zealand has shown that high rates of screening can be achieved where cervical screening is actively promoted. Women responded positively to a personal invitation and the interest shown in their health (Department of Health and the Cancer Society of New Zealand 1986, Moodie et al 1989).

5.1.5 Planning for the NCSP should take account of factors identified by women as necessary if they are to take part in cervical screening. These have been taken from the experiences of successful programmes overseas, the proceedings of the National Cervical Screening Workshop, and the recommendations of Judge Cartwright (Cartwright 1988, Chamberlain 1986, Eardley et al 1985, ICRF Coordinating Committee on Cervical Screening 1984, Report of the National Cervical Screening Workshop 1988, Smith et al 1989).

5.2 Necessary Factors for an Acceptable Service

5.2.1 Women need:

- . information about all aspects of the screening programme so that they can be responsible for their own health care needs
- . a service which is an effective means of reducing the chance of developing and dying from cervical cancer
- . an invitation to take part and a co-operative partnership with health care providers
- . a service which recognises the principles of the Treaty of Waitangi
- . screening to be provided in the context of wellness rather than illness
- . an affordable, accessible, culturally appropriate service
- . a choice of smear taker, and a choice of venue
- . confidentiality of personal information
- . involvement of women in all aspects of the planning and delivery of the service.

5.3 Barriers to Screening

5.3.1 A number of barriers that prevent women taking part in screening programmes have also been identified. These include:

- . practical difficulties - such as, the distance from a service, inflexible appointment systems, family responsibilities, and the cost of having a smear taken
- . a lack of sensitivity in the smear-taking procedure
- . an embarrassment about the procedure and a dislike of having it done
- . a perception of the test as a test for cancer rather than a preventive measure
- . an association of the test with sexual promiscuity and sexually transmitted diseases
- . a perception by older women that the test is not necessary for them

- . a fear of the results
- . fears about the possible misuse of personal information held in the screening programme's register
- . a previous unpleasant experience of screening
- . distrust of the cervical screening service in New Zealand because of previous unsatisfactory follow-up of women with abnormal smears.

5.4 Outline of Policy Statement

5.4.1 The remainder of this document outlines the various elements that comprise the NCSP. Each section has an overview followed by detailed implementation strategies. Section 6 develops strategies for an effective screening service, sections 7 to 9 detail the needs of priority groups, section 10 describes the programme's education policy, sections 11 to 14 deal with technical requirements, and sections 15 and 16 cover administrative responsibilities and funding for the NCSP.

6. STRATEGIES FOR AN EFFECTIVE SCREENING SERVICE

6.1 Overview

6.1.1 Women's prime contact with the NCSP will be the screening service, where smears are actually taken. In New Zealand the screening service will be provided by general practitioners, family planning clinics, community-based services, gynaecological specialists and hospitals.

6.1.2 The aims of the screening service are to:

- . increase screening coverage by inviting women to take part in the NCSP and by offering them choices in the type of service, venue, and sex of smear taker
- . provide a positive experience for women so that they continue in the programme
- . recall women at regular intervals
- . ensure that women with abnormal smears are diagnosed and treated.

6.1.3 In the absence of a comprehensive population health register with the ability to call women, existing primary health care providers - such as general practitioners and, to a lesser extent, family planning clinics - will continue to have the greatest influence on the nature and coverage of the screening service (Cox 1989). The doctor's invitation has been repeatedly documented as a key factor in the decision by women to take part in cervical screening (Bailie and Petrie 1990, Eardley et al 1985, Haran et al 1986, Moodie et al 1989). It is vital, therefore, that these groups are fully behind the programme and are committed to its success.

6.1.4 Over 90% of women in New Zealand visit a general practitioner every three years. This provides an opportunity for doctors to make use of a woman's contact with the health system for other reasons to initiate screening. The use of practice nurses, female doctors, smear-taking clinics, and special projects in co-operation with community-based women's groups will provide women with choices in a general practice setting. General practitioners who improve their screening service will benefit by being able to increase and retain their female clientele, and, with them, their families.

6.1.5 Some New Zealand general practitioners already have their own sophisticated computerised recall systems, while

others have manual recall systems (Moodie 1986, Moodie et al 1989). Doctors will be encouraged to develop their own systems, using the area health board register recall as a back-up. This approach will build on general practitioners' existing systems and so avoid undue duplication of effort. The board register supplies a board-wide management structure for service providers, which offers a regular recall system, an audit of the technical quality of smears, a safety net for the management of women with abnormal smears, and epidemiological data to assist in the improvement of screening services.

6.1.6 While research indicates that most women prefer their own doctor to take a smear, a choice of smear taker and venue has been shown to be important for a significant number of women (Eardley et al 1985, Grace 1985, Moodie 1986, Straton n.d.). A recent study in New Zealand (Bailie and Petrie 1990) showed that unscreened women were most likely to express a preference for an alternative smear taker, especially a woman smear taker.

6.1.7 Community-based screening services such as free screening clinics, well women's centres, work-based and marae-based clinics, and "suitcase" clinics widen the choice of service available to women. To be effective, such alternative services should be offered within a wellness context rather than being organised as a solely smear-taking service. Lay smear takers need to have a broad knowledge of women's health.

6.1.8 For community-based services to be successful, they must have public support and medical back-up. Lay smear takers should not work in isolation but as part of a community-based service which has links to general practice and diagnostic and treatment facilities. A process of consultation with the local community and with health professionals in the area is necessary to ensure acceptance and to establish goodwill.

6.1.9 It will be important for community-based services to be established as long-term and permanent structures if continuity of care is to be ensured. Smear takers have a continuing responsibility to the women from whom they have taken smears.

6.2 Implementation Strategies

6.2.1 The NCSP should be undertaken within the following resource constraints and requirements:

- . the encouragement of the greater use of existing primary health care services
- . the provision of appropriate services to women

- . the prevention of cost acting as a barrier to screening
- . the provision of high-quality standards of screening.

6.2.2 To encourage the greater use of existing primary health care services:

- . Area health boards should familiarise themselves with the screening systems already in place and work in a manner which encourages and complements them. Where computer systems already exist, care should be taken to try and establish an interface between them and other systems, particularly for laboratory services.
- . Area health boards should work with general practitioners to ensure that women are systematically invited to participate in screening. Special emphasis should be placed on strategies for involving women not currently being screened.
- . Within their own practices, general practitioners will need to develop strategies for identifying unscreened women and for systematically inviting all eligible women to take part in screening.
- . Procedures for enrolling women in the NCSP and updating information about them should be kept as simple as possible, so that they are not a disincentive to general practitioners participating in the programme.
- . The Department of Health and area health board cervical screening managers should make sure that providers are well informed about the NCSP and their role within it. Both the department and the boards should liaise with the professional associations, such as the Royal College of General Practitioners, the New Zealand Medical Association and nursing groups, medical schools, the Family Planning Association and the Cancer Society of New Zealand to ensure that providers have access to continuing medical education. This should cover all aspects of cervical screening, including strategies for improving screening coverage and the acceptability of services.
- . Undergraduate medical and nursing education should cover all aspects of cervical screening and the organisation of the NCSP.

6.2.3 To ensure that appropriate services are provided for women:

- . Area health boards should consult with the Maori and Pacific Island screening co-ordinators and community-based women's groups in their area.

- . Area health boards should provide funding for Maori, Pacific Island and other community-based initiatives in their area. Some funding will also be held at a central level for special projects for priority groups.
- . Area health boards should develop strategies to ensure that appropriate services are available for women with disabilities.
- . Area health boards should make sure that women have a choice of venue for smear taking and also a choice of smear taker - in particular, female smear takers must be available for women who want this option.
- . All smear takers will be eligible to receive a benefit. The availability of women smear takers, however, will be increased by practice nurses being eligible for a benefit at the same rate as general practitioners.
- . Area health boards should ensure that an up-to-date list of smear takers in their area is available to women.
- . Area health boards should develop strategies to ensure that all women have access to the results of their smears.
- . Area health boards should pilot and evaluate alternative services. This experience should then be shared with other boards through the national cervical screening co-ordinator.

6.2.4 To prevent cost acting as a barrier to screening:

- . A benefit will be provided for each screening consultation (rather than individual smear) carried out by a medical practitioner. The fee to women should be correspondingly reduced and boards are responsible for checking that this principle is followed in their areas. As well, a benefit will be paid to certified community nurse and lay smear takers for each screening consultation. At present a benefit of \$11 for medical practitioners and \$15 for alternative smear takers is paid in the pilot programmes in area health boards.
- . Area health boards should ensure there are some free or low-cost screening services in their areas. Non-medical smear takers working on these projects should negotiate their terms and conditions of employment directly with boards and should be remunerated from the board's grant for cervical screening.
- . The implications to the NCSP of the new contract system

* for general practitioners needs to be examined by the Department of Health.

6.2.5 To ensure that the screening service is both cost-effective and of a high quality:

- * . Area health boards should implement strategies to encourage doctors to adopt the NCSP's three-yearly screening regime and so discourage the too-frequent taking of smears. The Department of Health should also explore options for remedying this problem.
- . Smear takers must adhere to the national protocol for the management of women with abnormal smears. Boards should ensure that all smear takers are familiar with this protocol and should monitor its implementation.
- . All smear takers will receive an audit of the technical quality of their smear taking through the information stored on the cytology register.
- . All smear takers are expected to meet the Standards of Competency for Smear Takers set by the Department of Health and the Expert Group. Area health board medical officers of health will require smear takers who fail to meet the standards laid down in the Standards of Competency to undertake further training to improve their technique.
- . Area health boards will be responsible for making sure that people who wish to be smear takers have access to an approved training course. Guidelines for such courses will be set at a national level.
- . Medical officers of health will be responsible for the certification and continuing evaluation of community nurse and lay smear takers so that they can receive the smear-taking benefit. Practice nurses, working for general practitioners, will be encouraged to seek certification but this will not be mandatory. Doctors are taken to be already trained.
- . Area health boards must ensure that community-based services have access to adequate health professional support and supervision. It is important that boards fund community-based services in such a way that they are sustainable in the long term.
- . Funding should continue for the existing pilot community projects.

7. PRIORITY GROUP: MID-LIFE AND OLDER WOMEN

7.1 Overview

7.1.1 Mid-life and older women, that is, women 35 to 65 years, are a priority group for the NCSP since improving the screening coverage of these women will have a significant impact on reducing the incidence of cervical cancer. There are approximately 500,000 women in this age group and 145,000 are estimated to be unscreened. About 80% of women who die from cervical cancer and about 70% of women who develop the disease are 40 or more years of age (Cox 1989). Reaching these women will be a particular challenge to the NCSP and to service providers, especially general practitioners. This is because there are a number of perceived barriers to screening on the part of both the women and their general practitioners.

7.1.2 Many mid-life and older women have misconceptions and apprehensions about cervical screening. They may see screening as irrelevant and unnecessary for them - child-bearing is over and they are unlikely to be visiting the general practitioner or family planning clinic for matters requiring a vaginal examination such as pregnancy and contraception. They may feel embarrassed about the examination, especially if the doctor is male and/or young. They may not be as well informed about women's health matters and the need for screening as younger women. They are much less likely to initiate screening themselves. (Bailie and Petrie 1990).

7.1.3 Doctors themselves have differing policies and attitudes to screening in this age group. Some believe that screening should stop at menopause, or at some arbitrary age. They may find it harder to raise the topic when the purpose of the woman's visit has nothing to do with sexuality. Consequently, doctors are less likely to initiate screening with older women (Bailie and Petrie 1990, Grace 1985, Lancet 1985).

7.1.4 Mid-life and older women, however, may respond to a positive invitation to be screened. In an Australian study general practitioners systematically gave information on screening to women over 40 (who were attending their practices for other reasons) and then invited them to have a smear test. The result was that 50% of women who had not had a smear test for at least two years then had one (60% of those aged 40-65 years) (Cockburn et al 1990). Other doctors have used the system of "tagging" the notes of eligible women as a reminder to issue an invitation when the woman attends for any reason. Older women tend to have a

long-term relationship with their general practitioner and will take account of the advice given by him or her.

7.2 Implementation Strategies

7.2.1 To improve screening coverage in this priority group, service providers should adopt standard guidelines for screening mid-life and older women:

- . The Skegg recommendations on the ages for carrying out routine cervical screening should be followed by service providers (see paragraph 3.4.2). In summary, these are to cease screening at 65, unless the woman has had a previous abnormal smear or has never been screened before.
- . Women who have had hysterectomies for cervical abnormalities should have regular vault smears for life. (The Skegg recommendations do not provide guidelines for screening policy for all women who have had hysterectomies. The current revision of the guidelines is investigating this question.)
- . Women who have had hysterectomies but whose smears have always been normal and who have a current screening history can cease having smear tests. If the woman's smear history is out of date, she should have two normal vault smears at annual intervals and then cease having smear tests.
- . Women who have had a sub-total hysterectomy should continue screening as if they had not had a hysterectomy.

7.2.2 Screening coverage can also be increased by developing acceptable methods of inviting older women to participate. Area health board cervical screening managers should work with local general practitioners and their professional groups to develop strategies to reach older women.

7.2.3 Barriers to mid-life and older women taking part in screening can be reduced by:

- . Area health board managers consulting with older women in their areas about the acceptability of screening services and educational strategies. While there are no older women's groups specifically organised to work on women's issues, there are a number of groups which have a significant number of mid-life and older members, such as the National Council of Women, Country Women's Institute, the YWCA, Zonta, church groups, Age Concern, Sixties Up movement, Maori Women's Welfare League and the Women's Health League.

- . General practitioners making greater use of practice nurses as smear takers for women who are shy or embarrassed about a vaginal examination.

8. PRIORITY GROUP: MAORI WOMEN

8.1 Overview

8.1.1 Cervical screening is only one of a number of major health and social issues facing Maori women. The health of the woman and her whole family is important, not just the health of her cervix. Community development strategies will best meet the need for a holistic approach to Maori women's health.

8.1.2 Cervical screening providers should be aware of Maori concepts of health - concepts such as:

- . whanau - the well-being of the family and extended family
- . tinana, ao turoa - the physical elements of the body and the environment
- . hinengaro - mental and emotional health
- . wairua - spiritual health.

8.1.3 As well, whenua (the land) and reo (the language) are crucial factors in determining Maori health and well-being (de Boer and Pomare 1988).

8.1.4 Cervical screening for Maori women should be based on the principles of the Treaty of Waitangi. This will involve: the creation of working partnerships, encouraging participation, giving the full protection of the programme to Maori women by providing choice, and ensuring equity.

8.1.5 In some cases, to give full expression to these concepts will mean supplying Maori women with the resources to provide their own services.

8.1.6 There are approximately 86,000 Maori women in New Zealand between the ages of 20 and 64. Cervical screening must be offered to them in ways that they find acceptable, accessible and affordable if it is to be successful in reducing Maori mortality and morbidity from cervical cancer.

8.1.7 The aim is to achieve equity of outcome for Maori women in terms of cervical screening. This may involve a disproportionately high allocation of resources: much more work will be required to inform and convince Maori women of the benefits of the programme; and then to provide a screening service that meets their needs.

8.1.8 While many Maori women may wish to use the services of traditional health care providers, not all want to do so. There needs to be a choice so that Maori women can decide which type of service they will use - a saying which is true for Maori women is: "know my face before you know my cervix".

8.1.9 To promote choice, Maori women need access to training as smear takers. This training will conform to the standards and policies of the national programme. It will also require Maori women to meet their own kawa, tikanga (protocols, rules, standards governing practice, roles and behaviour) and wairuatanga (spirituality) pertinent to cervical screening and their own health status.

8.1.10 Bringing about the willing participation of Maori women is a process which will involve every aspect of the NCSP. For instance, information and educational resources about the NCSP's register should be fed in at every stage of the programme. Women will take part only when they are comfortable with the type of information about themselves that they will share, the people they will share it with, and how this information will be used.

8.2 Implementation Strategies

8.2.1 Seven Maori cervical screening co-ordinators should be funded by the Department of Health. They would be responsible to the national screening co-ordinator and would liaise with area health board screening managers and service providers to make sure that cervical screening is more equitable, accessible, and acceptable to Maori women.

8.2.2 Maori women need a co-ordinated system which recognises the principles of the Treaty of Waitangi, gives support at every level of the screening process, and provides effective educational strategies. This will be achieved by:

- . Providing funding at a national level for Maori women's groups to work on cervical screening activities.
- . Encouraging area health boards to consult with and support Maori women's groups in their regions.
- . Keeping the cost of screening for Maori women as low as possible. In some cases a free service for which koha is given will be appropriate, as happens now in the pilot community projects.
- . Protecting information held on the cytology registers about women who identify as Maori with a security code, and allowing access by others to this aggregated information only with the consent of a committee made up

of the Maori screening co-ordinators.

8.2.3 Area health boards are responsible for making sure that culturally appropriate cervical screening services are available in their areas. This can be achieved by:

- . Consulting with Maori women before planning decisions are made about cervical screening services for them. This will also involve negotiating with Maori women on the type and level of resources needed for a culturally appropriate service.
- . Giving Maori women's groups the resources to provide education and information to raise awareness about the screening service among their own people, and to deliver smear-taking services where appropriate. In some cases, this may involve providing employment for Maori women to carry out these tasks.
- . Involving, wherever possible, Maori nursing and support staff in screening, colposcopy and treatment services.
- . Identifying Maori nurses and other health workers who could train as smear takers and making available the necessary training.
- . Establishing community-based health services/clinics which include cervical screening in their services. The more mobile and community-based the service, the more accessible it will be.
- . Working with the professional colleges and post-graduate committees in universities to ensure that continuing nursing and medical education includes components on cultural awareness and the needs of Maori women.

9. PRIORITY GROUP: PACIFIC ISLAND WOMEN

9.1 Overview

9.1.1 To meet the goals of the NCSP for Pacific Island women, the screening service must be provided in a culturally appropriate manner.

9.1.2 The Pacific Island population has been increasing rapidly in New Zealand, so that nearly 4% of the total population is now of Pacific Island origin. There are approximately 28,000 Pacific Island women between 20 and 64 years of age living in New Zealand. There is a paucity of accurate information on screening rates among Pacific Island women and only a confused picture of the incidence of cervical cancer. There are some indications that Pacific Island women have significantly higher rates of cervical cancer than other women, but it has also been argued that these rates could be inflated by Pacific Island women coming to New Zealand for treatment for cervical cancer (Cox 1989, Gray et al 1989, Skegg and Cox 1989).

9.1.3 In planning a screening programme which will encourage participation by Pacific Island women, it must be recognised that Pacific Island women are not just one group. There are more than six main Island groups in New Zealand and between, and even within, these groups there are distinct differences based on language, citizenship, and cultural and religious behaviour. There are also differences between the 37% of Pacific Island women born in New Zealand and the 63% born in their Pacific Island homelands. The needs of these different groups may overlap but they are not identical.

9.1.4 For health services to be effective, they must be acceptable to the people who use them. For Pacific Island people, health is a state of complete physical, mental, social, spiritual, cultural and family well-being. The screening service should be developed within such a holistic context. It should be people oriented rather than problem oriented (Bailey 1990).

9.1.5 In the past, health programmes have been imposed on Pacific Island people, with the result that they have experienced a loss of autonomy and control (Lurch 1989). The NCSP should be empowering and offer a positive experience to Pacific Island women. If this is to be achieved, the following barriers to Pacific Island women's participation in the health services need to be overcome:

- . lack of communication because of language and attitudinal

barriers

- . difficulty in obtaining information because of inappropriate health education programmes
- . difficulty in obtaining services because of a lack of knowledge about services, cost, practical difficulties, and a reluctance to enter a strange environment
- . cultural values such as deference to authority and shyness (Bailey 1990).

9.1.6 As well, cervical screening is not a concept with which most Pacific Island women are familiar or necessarily comfortable. The genito-urinary tract is normally only exposed during childbirth. In some Pacific Island languages, there are no words for parts of the genital tract.

9.1.7 Recognising these barriers, great care must be taken by service providers to design educational programmes and deliver services that are culturally appropriate.

9.2 Implementation Strategies

9.2.1 Four regional Pacific Island cervical screening co-ordinators should be funded by the Department of Health. They will be responsible to the national screening co-ordinator and will liaise with area health board screening managers to make sure that cervical screening is accessible and acceptable to Pacific Island women.

9.2.2 Pacific Island women need co-ordinated systems which give support at every level of the screening process and provide effective educational strategies. This will be achieved by:

- . involving Pacific Island women in all stages of the planning and implementation of the screening programme
- . providing funding at a national level for Pacific Island women's groups to work on cervical screening activities
- . providing expertise and advice to Pacific Island women's groups through the Health Education Services of the Department of Health
- . encouraging area health boards to resource, consult with and support Pacific Island women's groups in their regions.

9.2.3 Area health boards are responsible for making sure that culturally appropriate screening services are available in their areas. This can be achieved by:

- . involving, wherever possible, Pacific Island nursing and support staff in screening, colposcopy and treatment services
- . increasing the availability of trained interpreter services, so that Pacific Island women receive information and advice in their own first language
- . identifying Pacific Island nurses and other health workers who could train as smear takers and making available the necessary training
- . establishing community-based health services/clinics which include cervical screening in their services
- . working with the professional colleges, post-graduate committees in universities, and polytechnics to ensure that continuing nursing and medical education includes components on cultural awareness and the needs of Pacific Island women.

10. EDUCATION POLICY FOR THE NCSP

10.1 Overview

10.1.1 The NCSP must seek to deal in advance with women's fears and anxieties. A client population of women who understand the purpose of screening is necessary if a cervical screening programme is to be successful. Health education is the means of making sure women are well informed.

10.1.2 The health education policy for the NCSP is based on the following principles:

- . A variety of strategies should be used as no one strategy will reach women of all ages and social and ethnic groups. Women are entitled to receive health information in a form and in the language with which they feel most comfortable. The use of health educators should be considered as one option, along with written and visual aids.
- . Women should be given sufficient information to make positive decisions about their own health care, rather than being told what to do.
- . Resources and strategies should build on women's existing knowledge, starting with what women know and moving from there to introduce new knowledge.
- . Clear, easily understood language should be used and jargon and alienating terms avoided.
- . Educational programmes should avoid an emphasis on so-called risk factors. Instead, women should be informed that cervical screening offers the only known effective preventive strategy. Specifically, sexuality should not be emphasised. Many women are shy about their sexual lives and do not wish sexuality to be a subject for public discussion. If publicity material highlights the link between sexual behaviour and cervical cancer, having a smear can appear to be a statement about a woman's own sexuality. Similarly, to stress the possible link between cervical cancer and sexually transmitted diseases can imply promiscuity. This could deter women from taking part in screening (Eardley et al 1985). These issues are of particular concern to older women, who are the most underscreened group.

10.1.3 The information provided in health education should cover:

- . The natural history of cervical cancer and the purpose of smear testing - with particular attention being given to distinguishing pre-cancerous conditions from cancer.
- . How the NCSP is organised and a woman's rights within the programme - she should know that she is entitled to her smear results and to "opt out" of the programme if that is her wish. This means that information about her will not be passed on to the cytology register nor will she be recalled by the programme.
- . The advantages the NCSP offers women - these advantages should focus on the individual benefits to each woman from joining the programme and the social benefits to women as a group from having a register that is as complete as possible.
- . The treatment options available.

10.2 Implementation Strategies

National Community Education Campaign

10.2.1 The introduction of the NCSP must be accompanied by intensive community education covering the areas listed above. Public support will be crucial to the programme's acceptance. The Department of Health will be responsible for this educational campaign, which must be designed to reach all New Zealanders and not just women at risk. The involvement of major women's groups in this community education campaign will be a key strategy and their support should be actively sought.

Continuing Health Education Information

10.2.2 In addition to this national community education campaign, an integral part of the NCSP must be the provision of information on a continuing basis.

10.2.3 The development of national educational resources is the responsibility of the Department of Health in consultation with the Expert Group.

10.2.4 Area health boards will be responsible for planning educational strategies to suit local needs, and will consult with the Department of Health on the development of resource materials.

Education Policy for Priority Groups

10.2.5 The NCSP has identified mid-life and older women, Maori women and Pacific Island women as priority groups within the programme. Special efforts need to be made to reach these women.

10.2.6. Strategies for achieving this will include:

- . Providing health education in Maori and English.
- . Using a self-help approach in which Maori women produce their own educational resources with the support and assistance of the programme.
- . Assisting Pacific Island women to develop their own educational strategies.
- . Providing health education in Pacific Island languages with trained interpreters where necessary.
- . Supplying resources to community-based groups which wish to provide health education for women. Resources for such work will be available at both national and area health board levels.
- . Consulting and working with groups in the community to make sure that health education strategies are appropriate.
- . Providing expertise and advice to women's groups through the Health Education Services of the Department of Health.
- . Developing educational strategies to reach mid-life and older women. This should be the joint responsibility of the Department of Health and area health boards. At a local level this might include the involvement of women's groups, such as business and professional women's groups, travel clubs, and sports clubs with an older membership.

TECHNICAL REQUIREMENTS FOR THE PROGRAMME

11. THE NATIONAL CERVICAL SCREENING REGISTER

11.1 Overview

11.1.1 The national cervical screening register consists of registers in each area health board linked to a central register (presently the National Master Patient Index), using common software, with strong national co-ordination and support.

11.1.2 The NCSP will improve cervical screening in New Zealand by bringing an organisational framework to the existing fragmented and opportunistic system. The management tool for providing that organisation will be a cytology register. The register will form a communication link between a woman, her smear taker, the laboratory and the area health board treatment services.

11.1.3 The objectives of the register are:

- . to ensure women with abnormalities are identified and adequately treated
- . to provide information about past cervical smears to laboratories to assist them in interpreting smears and making recommendations on treatment
- . to provide information to smear takers so they can provide the most efficient and effective service to women
- . to make sure all women screened will be recalled at appropriate intervals
- . to monitor the smear-taking process, including the quality of smears and the quality of smear reading
- . to measure the population coverage achieved
- . to identify women and population sub-groups who have never had a smear and invite them to participate in the NCSP.

11.1.4 Each area health board will maintain a cytology register for women in its area. Currently, each woman gives signed consent to be entered into the register. It is proposed that enrolment in the programme should become the standard procedure and that smear takers will be required by legislation to offer women the opportunity of opting out.

11.1.5 The cytology registers use the National Master Patient Index (NMPI) to generate a unique identifying number for each woman on the programme. The NMPI is also the communication link between the area health board registers.

11.1.6 It is envisaged that the cytology registers will improve significantly the overall quality of the screening service for women who are already enrolled on the programme, but in the short term they will not help in reaching unscreened women.

11.1.7 Successful cervical screening programmes elsewhere have population health registers. That is, lists of every woman in the target population with details of her screening history. These lists can then be used to invite and recall women, to identify unscreened women, and to keep in touch with women who move house (Bowling and Jacobsen 1989, WHO 1986). No such register exists in New Zealand.

11.1.8 In time the NMPI may develop into a complete population health register, and at that stage could be used for "call". Alternatively, the electoral roll could be used to invite individual women to participate in the programme. There are no immediate plans to implement either of these options. Some measure of population coverage is presently achieved by the NMPI in conjunction with the register by domicile code not census area units.

11.1.9 As currently configured, the cytology registers are confined to recording cytology results only. Expansion to include relevant histology is an urgent priority, not only to ensure that women with abnormal smears are being properly followed up but also to evaluate the quality of smear recording in laboratories.

11.2 Implementation Strategies

Enrolment on the Register

11.2.1. A woman will normally be enrolled at the time of her first smear with the programme.

11.2.2. As currently happens in the area health board pilot programmes, women give signed consent to be enrolled in the register. It is the Expert Committee's view that enrolment on to the register should be routine, that is, women are enrolled automatically unless they elect to opt out. The processes involved, the purpose of the register and the right to opt out will be explained by smear takers to women at the time of the first consultation. Women should be told what information about them is held on the register and how they can obtain access to it. The possible legal and ethical implications of this policy need to be fully ascertained by the Expert Group and the Department of Health, and, if necessary, legislation should be proceeded with. (A model for this can be found in the Victorian Cancer (Central Registers) Act 1988.)

11.2.3 Information collected during enrolment should be consistent across area health boards to allow comparative monitoring and should include only that information necessary to carry out and monitor the NCSP. A question on ethnicity will be included on the enrolment form.

* 11.2.4 The concept of developing the NMPI into a well-managed complete population health register needs to be explored. A committee which includes representatives of the Expert Group, the Department of Health, and professional groups should examine this as the implications extend well beyond cervical screening. In any case, the Department of Health should also research and report to the Expert Group on the feasibility of using the NMPI and/or the Electoral Roll in an active "call" of women to participate in the programme.

Letters and Reports Generated by the Register

11.2.5 The area health board cytology registers accept results from laboratories only in an electronic format - there are no facilities for manual entry of smear results. The Department of Health has developed software for a cervical cytology system which will be given free of charge to laboratories to assist them in developing electronic recording of results.

11.2.6 Linkage to the NMPI will make it easier to track women who move, but this will depend on the women contacting their local hospital or having another smear. A woman's general practitioner is likely to have her correct address and also to know her personal circumstances - for example, that she has had a hysterectomy. Area health boards therefore should develop close relationships with general practitioners in their area and work in with doctors' own recall systems. To help in keeping the register as up to date as possible, lists of women to be recalled will be sent to the smear taker. This will allow the smear taker to contact the woman direct and, if appropriate, to update details on the register.

11.2.7 Having assessed the letters and reports generated in pilot programmes, it is the view of the Expert Group that the NCSP will generate the following letters and reports to smear takers and women:

- . Advice of results to smear takers (the current practice of laboratories reporting directly to the smear taker will continue).
- . The initial result letter to women. This letter will follow first smears with the programme and will include:
 - a welcome to the programme and an opportunity to check

accuracy of personal details

- the results of the smear test, whether normal or requiring further action
 - advice that after subsequent smears letters will only be sent if the smear results require further action
 - an explanation of recall procedures and how normal results can be obtained after future smears
 - the woman's NMPI number for future reference.
- . Letters to women advising them that smears are not normal and require further action. Letters to women containing smear results should be brief and simple, with referral to the smear taker for further explanation in the case of abnormal results.
 - . Reports to smear takers when women with abnormal or inadequate smears have not been followed up.
 - . Recall letters for women and lists of recall names for smear takers. These names will be sent to smear takers before women are recalled by the register, to enable smear takers to contact women first.
 - . Lists of overdue recalls for smear takers.

11.2.8 The NCSP will generate the following management information reports:

- . Reports on the quality of smears and reports on smear turn-around times.
- . Benefits payment reports, to provide confirmation to benefits payments offices of the number of screening consultations undertaken by a service provider.
- . A statistical report on the quality of smear reading to laboratories.

11.2.9 Representatives of both the Department of Health and the Expert Group should research and report to the Expert Group on the methods by which relevant histology data can be obtained and used by the programme. This review should include an assessment of direct submission of histology results to the cytology registers, the possible use of the National Cancer Registry for the initial registration of the histology results, and the possible legislative requirements involved. This review is regarded as a matter of urgency by the Expert Group.

Privacy and Confidentiality of Personal Information

11.2.10 Although New Zealanders entering public hospitals have been registered on the NMPI for several decades, there has been little public discussion of the concept of health registers. There has been apprehension on the part of women about this aspect of the NCSP. Women need to be certain that the benefits to them from the information collected for the NCSP outweigh the cost and perceived harm from compiling the information in the first place. Maori women, in particular, are concerned that they have become "over researched" in recent years, and wish to have some protection about how information collected for the register is used.

11.2.11 Safeguards to maintain confidentiality and protect the information held in the register will need to be built into the NCSP:

- . When enrolling a woman on to the programme a smear taker must tell her the purpose for which the information is collected, the authorisation under which it is collected, and who will have access to the information.
- . It is the responsibility of the smear taker/programme manager to ensure that the information collected is up-to-date and complete, and that confidentiality is protected. Area health boards should develop policies to ensure that these requirements are met.
- . Records must be protected by adequate security safeguards against loss, or unauthorised access, use, modification, or disclosure. Access to computer records must be protected by a password which should be changed at least once a month. Access to non-personal aggregated information will require the permission of either the area health board programme manager or the NCSP national co-ordinator.
- . Access to non-personal aggregated information on Maori women can be made available only with the approval of the Maori cervical screening co-ordinators.
- . Women should have access to the information about them stored on the register. The procedure for obtaining access should be consistent with the requirements of the Official Information Act 1987.

Monitoring

11.2.12 Epidemiological information from the registers should be analysed at regular intervals to monitor the success of the NCSP in reducing mortality and morbidity from

invasive cervical cancer. The ability to carry out this function is being developed by the Department of Health. This information can also be used in designing strategies to reach unscreened women. Access to information about Maori women will require the permission of the Maori screening coordinators.

11.2.13 Information submitted to the National Cancer Registry concerning cervical cancers should be made available to the NCSP to provide further information necessary for the evaluation of the programme.

11.2.14 To enable sensible evaluation and to make efficient use of the cytology register, the Department of Health needs to develop a method of using death certificates to clear the register of dead people.

12. LABORATORIES

12.1 Overview

12.1.1 Laboratories and their staff will play a key role in the services of the NCSP, as it is through laboratories that cytological information will be collected and recall dates normally set. The efficiency of the cervical screening programme will depend on high standards of smear reading by laboratory technicians and an acceptable turn-around time for reporting on smears.

12.1.2 New Zealand's community laboratories have combined to support the NCSP. The Royal College of Pathologists of Australasia, the New Zealand Society of Pathologists, the New Zealand Society for Cytology, and the New Zealand Institute for Medical Laboratory Technology formed a joint committee, the Cytology Advisory Liaison Committee (CALC), which has assisted the introduction of the NCSP. CALC has successfully promoted the adoption of a single, uniform, easily computerised system (the Bethesda system) for reporting cervical cytology throughout New Zealand.

12.2 Implementation Strategies

12.2.1 The role of the laboratories in the implementation of the NCSP will be:

- . to provide an efficient, timely, and accurate service for processing, examining and reporting cervical smears
- . to report cervical smears according to the Bethesda Classification, which may be modified as required with the approval of CALC
- . to communicate the reports on cervical smears to the appropriate area health board cytology registers in an agreed format suitable to both the laboratory and the registers.

12.2.2 The Expert Group recommends that by 1991 all cytology laboratories servicing the NCSP should have applied for registration with the Testing Laboratory Registration Council of New Zealand (TELARC) and should be TELARC registered by December 1993. The only exceptions will be if TELARC itself is unable to meet these deadlines or if a laboratory is newly set up, necessitating a reasonable period of time in which to obtain TELARC registration.

12.2.3 The Department of Health should be responsible for confirming that those laboratories carrying out cytology screening for the NCSP meet the recommendations set out in 12.2.2. Such confirmation should become a requirement for receiving the laboratory benefit for reading NCSP smears.

12.2.4 The criteria for registration by TELARC should be negotiated with TELARC by CALC and the Department of Health. The criteria will include guidelines on:

- . the reading of a minimum number of smears a year
- . the employment of adequate numbers of suitably qualified staff
- . the maximum workload for each cytoscreener
- . adequate in-service education
- . the satisfactory participation in both internal and external quality assurance procedures
- . co-operation in providing cytology reports to the cytology register.

12.2.5 The Department of Health, CALC, TELARC, and other relevant organisations will set standards for the training of cytology laboratory assistants. The Department of Health is responsible for ensuring that there are sufficient training facilities to meet the cytology screening workforce requirements of the NCSP.

12.2.6 Developing a mechanism for linking the histology results of cervical tissues submitted to laboratories for diagnosis to the cytology register is an urgent priority for the Department of Health. The register will also be developed so that laboratory staff have direct access to a woman's previous smear history when reading smears.

13. COLPOSCOPY AND TREATMENT SERVICES

13.1 Overview

13.1.1 An essential element in a successful cervical screening programme is the availability of prompt, high-quality diagnostic and treatment services. Currently, the special funding for cervical screening does not cover colposcopy or treatment, so it will be the responsibility of area health boards to make sure that they have sufficient services to meet the increased demand generated by the introduction of the NCSP.

13.1.2 An abnormal smear can cause women a great deal of anxiety, and it is unacceptable that they have to wait excessively long for a colposcopy. Provision of acceptable services requires not only technology but also adequately trained staff to use it. For boards to meet the requirements of the NCSP, both equipment and staff training will need to be adequate.

13.1.3 Treatment procedures should meet the following general principles:

- . Treatment should ideally be performed by the same person who performed the colposcopy. That person should either be a gynaecological specialist or be supervised by a gynaecological specialist, and he or she should be able to give an adequate explanation of the pathology and the risks and benefits of treatment.
- . Laser treatment should only be undertaken by a suitably trained gynaecological specialist or by a medical practitioner who is under appropriate gynaecological specialist supervision. The Royal New Zealand College of Obstetricians and Gynaecologists guidelines should be followed where laser treatment is undertaken.
- . The treatment offered should be tailored to the skills of the medical practitioner and to the type of local facilities available. It is the responsibility, however, of the medical practitioner to refer women elsewhere if appropriate treatment is unavailable locally.

13.2 Implementation Strategies

13.2.1 Area health boards should provide colposcopy and other services for the diagnosis and treatment of cervical cancer which can meet the standards of the Women's Abnormal Smears National Consensus on a Treatment Protocol for Management (Department of Health 1989). The standard

requires that urgent colposcopy must be available within one month of referral, with non-urgent colposcopy being available within 3 to 6 months of referral. Boards should also note the recommendation in the treatment protocol that these waiting times should in the long term be reduced to urgent colposcopy being available within one week of referral, with non-urgent colposcopy being available within one month.

* 13.2.2 Waiting times for colposcopy should be monitored by the Department of Health to make sure these guidelines are not exceeded. Boards are responsible for ensuring that no women go on to treatment without having had a colposcopy.

13.2.3 The provisions in the treatment protocol for the management of women's abnormal smears must be complied with and monitored. For women who remain in the same board area, monitoring should be done through the cytology register. Special efforts must be made not to lose contact with women who have had treatment and are now living in another board's area. (This protocol will be reviewed in September 1992 or earlier if changes in the Skegg recommendations warrant it.)

13.2.4 Training in the various treatment options available for pre-cancerous conditions of the cervix should form part of the general training of gynaecologists before they receive recognition as specialists.

13.2.5 To meet the standards set out in the protocol, there must be adequate provision of both colposcopy equipment and trained staff. Colposcopy is now included in medical undergraduate courses, but most practising colposcopists have not undertaken any formal training in colposcopy. As well, the level of skill and experience of colposcopists varies. The following actions are needed to make sure that all staff have sufficient levels of training:

- . Area health boards should ensure that post-graduate training is available to colposcopists in their area.
- . The practice of colposcopy in all boards should comply with the guidelines developed by the Royal New Zealand College of Obstetricians and Gynaecologists and the New Zealand Society of Colposcopy and Cervical Pathology. These specify that gynaecological specialists who undertake treatment for pre-malignant change in the lower genital tract should have attended at least one formal colposcopy course run by a recognised teacher. The specialists being trained through this course must perform supervised colposcopy with an experienced colposcopist. This supervised teaching should be equivalent to one weekly session for twelve months, where a minimum of five new cases are seen and are available for teaching at each session.

- . Colposcopists should attend regular pathology/cytology meetings, and the board should make available to colposcopists the facilities to record treatment services and to audit their results.
- . Practising colposcopists should see a minimum of 4 new cases a week (200 new cases a year) to maintain their competence in this area.

13.2.6 The above training constitutes the minimum requirement for a colposcopist providing colposcopy as a diagnostic service. Separate training and audit procedures must be developed for personnel who undertake treatment services and who are not an obstetric and gynaecological specialist or under the supervision of one.

13.2.7 Not all boards will be able to offer the required colposcopic expertise or the full range of treatment options. This includes the assessment and treatment of pregnant women or women with primary treatment failure. These women therefore should be referred to other boards where specialist services are available.

13.2.8 Treatment for invasive cervical cancer is currently available at five centres - Auckland, Hamilton, Wellington, Christchurch and Dunedin. Further treatment facilities should not be developed in New Zealand. If the cervical screening programme is successful in reducing the incidence of invasive cervical cancer, the demand for treatment can be expected to drop which may result in a reduction in the number of centres providing treatment.

13.2.9 The travel costs of women who have been referred from one area health board to another will be met by the referring board. This is not the case for referrals to, from or within the private sector. These travel costs and any professional fees must be met by the woman herself.

14. EVALUATION AND MONITORING

14.1 Overview

14.1.1 While the ultimate objective of the cervical screening programme is to reduce mortality from cervical cancer, there will be a considerable lag before the impact of the changes to cervical screening are reflected in mortality rates. Effective monitoring of area health board performance will therefore require consideration of a wide range of performance indicators that, when viewed together, will provide an overall indication of each area health board's performance.

14.1.2 It should be stressed that no single indicator - with the possible exception of the mortality rate - exists which measures good performance. A total picture can only be developed by monitoring all aspects of the programme.

14.2 Implementation Strategies

Area Health Board Evaluation

14.2.1 It will be the responsibility of area health boards to collect monitoring information according to the NCSP's required performance indicators and use this information to evaluate the success of the programme within board regions.

14.2.2 Performance indicators for area health boards should be developed by the Department of Health in consultation with the Expert Group and then negotiated with area health boards.

14.2.3 The national evaluation of the NCSP will require certain core information to be collected in a consistent manner across all boards. This relates primarily to various technical aspects of the NCSP. Boards will also need to evaluate other aspects of the programme, such as the acceptability of the service. As part of their implementation plan, boards should include a proposal detailing how these aspects will be evaluated in their region.

14.2.4 Aspects of the programme that require evaluation will include:

- . screening coverage in all age and ethnic groups
- . the identification of priority groups
- . the special efforts being made to screen priority groups

- . the level of overscreening (that is, screening more frequently than specified by the Skegg recommendations)
- . the quality of smears taken
- . the turn-around time for smears
- . the quality of smear reading
- . the follow-up of women with abnormal smears
- . waiting times for colposcopy and treatment
- . treatment failure
- . the security of the register
- . privacy of information
- . the efficiency of the register for smear takers
- . enrolment procedures
- . doctors' understanding of the programme
- . the professional education available
- . the training and evaluation of smear takers
- . the choice of services available to women
- . the choice of smear takers available to women
- . women's access to smear results
- . the cost of the screening service to women, including the reduction of medical fees
- . the cultural acceptability of screening and treatment services
- . the provision of trained interpreter services
- . health education programmes
- . women's satisfaction with the service
- . recall response rates and accuracy of letters sent to women
- . consumer involvement in planning
- . resources given to community groups

- . the pilots of service delivery projects.

National Evaluation

14.2.5 The national cervical screening co-ordinator will be responsible for ensuring that the NCSP is monitored and evaluated on a national level. It is also the co-ordinator's role to make sure that progress towards achieving the goal and objectives of the NCSP is evaluated. Epidemiological information will be available from the register. To date, no software has been developed to carry out this task. This aspect of the register will be developed by the Department of Health with the advice of relevant experts, including an epidemiologist and a biostatistician. As part of this process, consideration will need to be given to the consequences for epidemiological studies of women being able to opt out of the NCSP. There will be no information available on those women for evaluating the success of the programme.

Continuing Evaluation

14.2.6 An evaluation component should be incorporated into the planning of all future cervical screening projects. This will assist in improving various aspects of the national programme, including the delivery of alternative services. Evaluation of projects and services should be co-ordinated nationally by the Department of Health.

14.2.7 New strategies should be piloted and evaluated before they are introduced on a large scale. Experience from pilot projects should be shared nationally through the national screening co-ordinator.

Economic Evaluation

14.2.8 Some type of economic evaluation is essential if the criteria of accountability and efficiency in resource use are to be satisfied. This calls for close collaboration with health economists in the planning process and in the systematic collection of the necessary data. This data should include:

- . direct government costs
- . costs associated with the diagnosis and treatment of any abnormalities detected
- . additional costs imposed on both the public and private health services

- . the personal costs to women of the screening process and any follow-up care
- . the savings where costs of future treatment for cancer and pre-invasive conditions are averted by earlier detection.

14.2.9 Information about all of these costs and benefits should be collected and analysed systematically as part of the monitoring and evaluating process. The net economic costs could then be related to various outcome measures, such as the number of cancers prevented, lives saved, and years of life saved. With this information, it should be possible to compare the cost-effectiveness of different levels of screening as well as the cost-effectiveness of cervical screening compared with other health services. The simulation computer programme used by Cox in his study (1989) could well be adapted to the economic evaluation of the NCSP.

ADMINISTRATIVE RESPONSIBILITIES

15. RESPONSIBILITIES OF DEPARTMENT OF HEALTH, AREA HEALTH BOARDS AND EXPERT GROUP

15.1 Overview

15.1.1 The NCSP is nationally co-ordinated, but implemented by area health boards. To bring this about the Department of Health should develop an effective national resource unit to provide advice, support and guidance to area health boards. The department should also work closely with the Expert Group, appointed to advise the Minister of Health on policy for the NCSP. At a national level, the national cervical screening co-ordinator has primary responsibility for ensuring that the Department of Health carries out its tasks. At area health board level, a cervical screening manager is responsible for the implementation of the NCSP in that region.

15.1.2 Both the Department of Health and the area health boards will be responsible for implementing the policy contained in this document. Specific policies are outlined in sections 3 through to 14. In the remainder of this section an overview is provided of the main responsibilities of the department and area health boards and their relationship with the Expert Group. Specific implementation strategies are also recommended for how these functional relationships could operate in practice.

15.1.3 The main responsibilities of the Department of Health are as follows:

- . to provide funding for the NCSP consistent with the funding policy in section 16 of this document
- . to implement aspects of NCSP policy which have national implications
- . to develop strategies to ensure the public is well informed about the NCSP and supports its objectives
- . to enter into contracts with area health boards to ensure that NCSP policy is being implemented in their region
- . to provide advice and support to area health boards
- . provide training and development for area health board screening managers
- . to develop and modify the software for the register as necessary, in consultation with area health boards
- . to draft and advise on the legislation needed to allow the

transfer of information from laboratories to the register, to provide for women to "opt out" of the programme, and to enable histology to be included on the cytology register

- . to set performance indicators for area health boards, in consultation with the Expert Group
- . to set standards of competency for smear takers and guidelines for training courses in consultation with the Expert Group
- . to evaluate the experience of the pilot screening programmes in area health boards
- . to co-ordinate monitoring and evaluation of the programme and evaluate whether the goal and objectives of the programme are being met nationally
- . to provide advice and support to the Expert Group
- . to ensure that privacy and confidentiality standards are established for the NCSP and met.

15.1.4 The main responsibilities of the area health boards are as follows:

- . to implement a cervical screening programme in the board's area consistent with the NCSP policy
- . to make sure there are no barriers to women taking part in screening
- . to identify priority groups in the board's area and, in consultation with these groups, to develop strategies to bring about their participation in screening
- . to work with traditional service providers in each area to ensure that appropriate services are provided and that maximum use is made of existing services
- . to work with the Maori and Pacific Island screening co-ordinators to ensure that services meet local needs
- . to ensure that widespread community consultation takes place about all aspects of the screening programme
- . to ensure that smear takers have access to approved training courses
- . to ensure that the Standards of Competency for smear takers are met
- . to maintain a cytology register

- . to develop a policy to maintain the confidentiality of information held on the cytology register
- . to ensure that there are adequate diagnostic and treatment services in the region to meet the needs of the NCSP
- . to monitor and evaluate the programme in the board's area and to provide data to the NCSP for national evaluation.

15.1.5 The main responsibilities of the Expert Group as set out in the Review Committee's report are:

- . advising the Minister on national policy and resource allocation
- . overseeing the implementation of the NCSP
- . identifying priority groups of women who should be given special attention
- . monitoring national education and publicity material
- . liaising with the national co-ordinator
- . overseeing the introduction of treatment protocols
- . reviewing the overall effectiveness of the NCSP
- . advising on the setting of performance indicators and realistic targets for area health boards.

15.2. Implementation Strategies

15.2.1 To ensure that the above responsibilities are carried out, a national co-ordinator has been appointed within the Department of Health. The national screening co-ordinator acts as a link between area health boards and the Expert Group. She should brief the Expert Group on progress being made in the area health boards and advise them of any problems which have arisen. It is her role to take any concerns of area health boards to the Expert Group.

15.2.2 The national screening co-ordinator will make regular reports to the Expert Group on progress in implementing the NCSP.

15.2.3 The national screening co-ordinator should meet regularly with area health board screening managers to share information and experience in implementing the programme.

15.2.4 The national screening co-ordinator is responsible for producing a regular newsletter to inform area health boards, interested groups and individuals of developments in the programme.

15.2.5 The Department of Health should consult widely with provider and women's organisations to obtain their support for the NCSP.

15.2.6 Area health boards should report on a regular basis to the Department of Health on the implementation of the NCSP policy in their area. This will include information on the progress being made towards achieving the objectives of the programme and epidemiological data for the national monitoring and evaluation of the programme.

15.2.7 Area health boards should consult with all relevant professional and community organisations in their area to ensure that screening services are appropriate, accessible and equitable.

15.2.8 The Expert Group will provide feedback and advice to the Department of Health and ultimately advice to the Minister of Health.

16. FUNDING FOR THE NCSP

16.1 Current Funding

16.1.1 In July 1989 the government approved special funding over a three year period for the NCSP. Expenditure of \$14.0 million was approved for the 1989/90 financial year, and \$11.8 million for each of the two subsequent financial years.

16.1.2 The Expert Group does not have the information to make recommendations about every detail of the NCSP's initial three year budget, but it does support a number of specific recommendations:

- . That a full-time salary for a national co-ordinator continue to be funded centrally.
- . That a full-time salary for a cervical screening manager in each area health board be funded centrally, and that this funding not be transferable to other area health board cervical screening activities.
- . That full-time salaries for seven Maori screening co-ordinators and four Pacific Island screening co-ordinators be funded centrally.
- . That establishment costs for the area health board screening registers be met centrally, and that after three full years of operation running costs be met by boards.
- . That sufficient funds be set aside for health education and promotional activities. While some of this funding should be spent centrally, the rest should be distributed to area health boards for expenditure on cervical screening as part of board cervical screening plans.
- . That the funding to area health boards for health educational and promotional activities be increased proportionally for those boards with higher percentages of the NCSP's priority groups in their populations.
- . That general practitioners and family planning clinics will be paid a smear-taking benefit for each screening consultation (rather than for each individual smear). This benefit should be passed on to the woman in the form of a reduced fee. The benefit will be identified separately from the other benefits general practitioners and family planning clinics are paid through the benefits payment system. General practitioners will be able to

continue to claim the GMS for women from whom they are taking cervical smears, or the relevant practice nurse subsidy if their nurses are taking smears.

- . That a benefit also be available for certified community nurse and lay smear takers.
- . That a grant be made to each area health board for the organisation of the NCSP at board level. The grant will be made on the basis of the estimated number of smears to be taken in a given year. This estimate will form part of a cervical screening plan which in the first year will be sent to the national co-ordinator of the NCSP for approval. In subsequent years, cervical screening plans will be part of the contractual agreements between boards and the Minister of Health. The plans will also include provision for special smear-taking projects to reach priority groups, and should include the provision of some free or low-cost smears.
- . That grants made to area health boards as part of the NCSP be tagged for cervical screening.

16.2 Continuing Funding

16.2.1 To date no decision has been announced on whether the special funding will continue after the first three years. To meet and maintain the national health goals and targets for cervical cancer, a sustained programme is essential. While a concentrated injection of resources in the first three years is expected to increase screening coverage, the reduction in the incidence and mortality rate from cervical cancer, which is the goal of the programme, will not occur if women do not continue to return for recall smears in future years. The failure to sustain satisfactory screening coverage will mean that the resources invested in the first three years will be wasted.

16.2.2 The Expert Group therefore recommends that continued funding should be voted for the NCSP, as the survival of the programme will be at risk if it has to compete for funding with other Department of Health and area health board services.

16.2.3 At a national level, funding will be needed for the following continuing aspects of the NCSP:

- . the full-time salary of the national co-ordinator
- . the development and maintenance of the cytology register
- . the full-time salaries for the Maori and Pacific Island screening co-ordinators - Maori screening co-ordinators

may in future be employed through iwi authorities

- . the payment of screening benefits
- . the regular monitoring and evaluation of the NCSP as a whole to ensure goals and targets are being achieved
- . the four pilot projects involving Maori and low-paid women
- . the special fund for priority groups
- . the payment of the Laboratory Benefit to cover all smears done under the NCSP
- . the continuation of the Expert Group

At an area health board level, funding will be needed for these continuing aspects of the NCSP:

- . the salaries of screening managers and staff, including computer operators for the register
- . the provision of a choice of smear taker and venue for women
- . the provision of cheap or free smears
- . the provision of health education to sustain levels of awareness and educate younger women entering the priority group
- . the diagnostic and treatment services to meet the requirements of the NCSP for training and evaluation of smear takers.

LIST OF REFERENCES

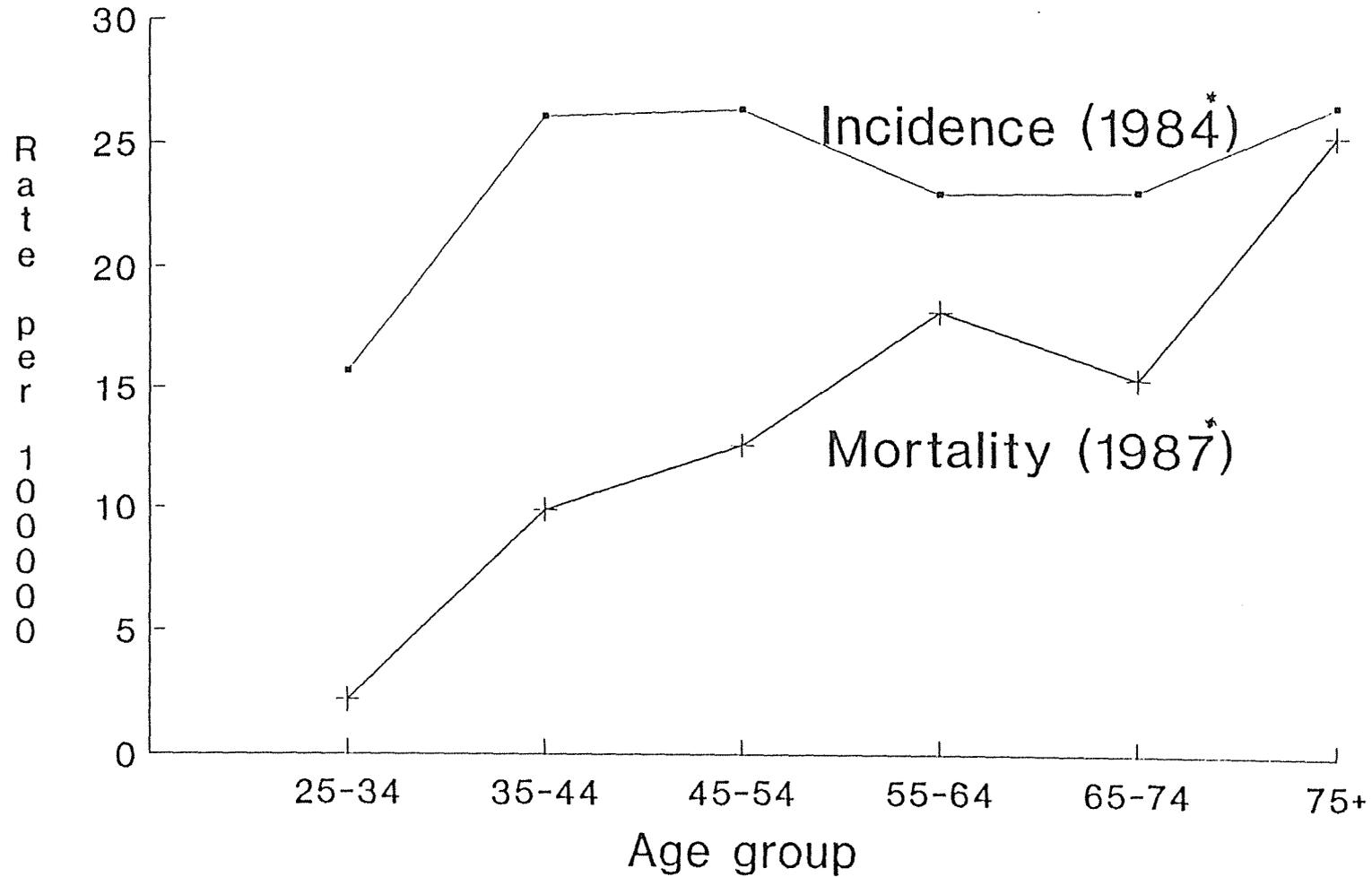
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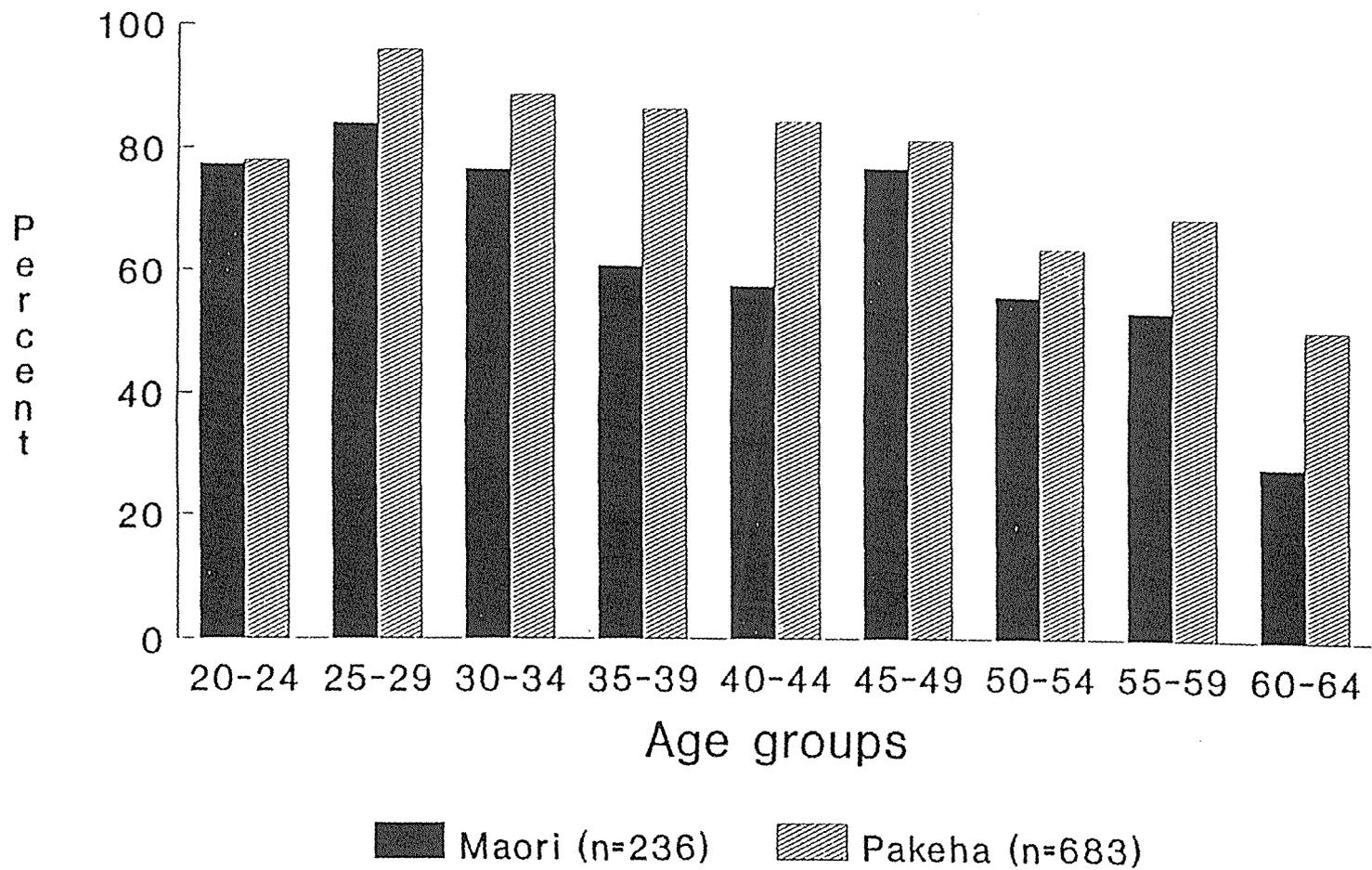
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Figure 1: Cervical cancer in NZ women
Incidence and mortality rates per 100000



* Last year for which data is available

Figure 2: Cervical smears
Reported rates within previous 3 years



NRB Survey, July 1990



(date print)

Dear

I am writing to seek your assistance with a thesis which I am hoping to write and complete this year. The thesis is in partial fulfilment of the degree of Master of Education Administration.

For this thesis I have elected to conduct a case study of the development of social policy for the National Cervical Screening Programme. I am particularly interested in the consumer input into the policy for this programme.

As you were a key player in the development of this policy, I am writing to request an interview to elicit your views relating to the development of policy in the National Cervical Screening Programme. Subsequent to the interview, there will be a Questionnaire which I hope you will agree to answer.

I will attempt to protect the identity of particular individuals within the thesis by the non-use of personal names. I wish to point out, however, that there are a limited number of individuals who have been involved in the development of this policy and therefore your identity may be known, in general terms.

If you agree to participate in this study for the thesis, I will ensure that any written material which relates to you personally will be provided to you for comment prior to the final draft.

The thesis will not be published, and therefore, will not be freely available for others to read. The acting Director-General has required that a further restriction be placed on the thesis. The thesis will be held in the closed section of the library at Massey University. This restricts access to the thesis even further.

I sincerely hope that you will agree to assist me with this particular study. If you require further clarification about the contents of this letter, please do not hesitate to contact me. My address is above and my telephone numbers are as follows: Business: (04)496 2286 or Home: (04)760 071 (collect).

Thank you, in anticipation of your consideration.

Yours Sincerely

Gillian Grew

CONSENT TO BE INTERVIEWED FOR RESEARCH PURPOSES

I _____ have on this
day of _____ 1991, agreed to be interviewed by
Gillian Grew for the purpose of discussing the
development of policy for the National Cervical Screening
Programme.

The information provided by me may be included in
Gillian's report for a thesis written in partial
fulfilment of the degree of Master of Education
Administration.

I understand that my personal name will not be used in
the written report and that all comments made by myself
will not be attributable directly to me personally
.

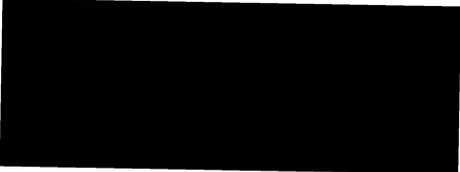
I understand that Gillian will provide me with a written
transcript of the interview so that I may comment on and
critique it. I further understand that I have the right
to require Gillian to delete any written material
attributable to myself, if I so wish.

Signed:

Date:

Signed:

Date:



13 October 1991

Dear

Further to my interview with you on 8 October 1991, I am pleased to enclose a set of notes that are based on the recording I made during our meeting.

Would you please check over the written notes to:

- a) Ensure that the information I have recorded is accurate to the best of your knowledge;
- b) Ensure that I have retained the sense and meaning that you intended;
- c) Indicate any matters that I may use in my report which will not be attributed to you;
- d) Indicate any matters that you do not wish me to use (I have already removed some comments that you did not wish to have recorded) and
- e) Indicate any omissions.

Please feel free to mark the written comments accordingly.

Should there be anything that you would like to discuss with me please call me either at the Department of Health, telephone 496-2286 or at home, telephone 760-071.

I would appreciate it if you would return the notes to me in the enclosed envelope, as soon as possible.

Thank you for your assistance.

Yours sincerely

Gillian Grew

QUESTIONS FOR INTERVIEWS: NATIONAL CERVICAL SCREENING
PROGRAMME

1. Situational Factors:

1.1 Are there any particular events that occurred in New Zealand which, in your opinion, influenced the development of this particular policy?

1.2 How important was the personality of leadership in policy development? Explain.

1.3 Did any particular group or organisation have a central influence on the development of this policy? Explain.

1.4 How important was this policy in relation to others, during its development? Explain.

2. Structural Factors:

2.1 What, in your opinion, is the role of the State in health care?

2.2 How would you describe the role of the State in terms of this particular policy?

2.3 Did this particular policy reflect the political ideology at the time of its inception? Explain.

2.4 Were there any prior policy commitments which may have influenced the development of this policy?

2.5 How did this policy fit with other health policies of the time? Explain.

2.6 How would you describe New Zealand's economic conditions?

2.7 How did economic issues influence the development of this policy?

2.8 Is this policy economically sustainable? Explain.

2.9 In terms of the Treaty of Waitangi, what particular issues arose in the development of this policy?

2.10 In your opinion, does this policy satisfy the partnership requirements contained in the Treaty of Waitangi? Explain.

2.11 Would you describe this policy as broadly top-down or broadly bottom-up? Explain.

2.12 Did or does this policy have the political support of administrators? Explain.

2.13 Were there any particular groups which supported the development of this policy? Explain.

2.14 Were there any particular groups which were against the development of this policy? Explain.

2.15 Do you think that this policy will be successfully implemented? Explain.

3. Cultural Factors:

3.1 Does this policy reflect the divergent cultural values of New Zealand's population today? Explain.

3.2 What particular cultural values are embodied most prominently in this policy?

3.3 In your opinion, does this policy have popular support? Explain.

3.4 What do you personally consider to be the social and moral implications of this particular policy?

4. International Factors:

4.1 Can you identify any international events that may have influenced the development of this New Zealand social policy?

4.2 Can you describe any international social policies that may have influenced the development of this New Zealand policy?

4.3 In your opinion, is New Zealand policy development in Health, influenced by any country(ies) in particular? Explain.

4.4 Are you aware of any international agreements and obligations which may have influenced the development of this policy in New Zealand?

5. More Personal Factors:

5.1 Describe the various forms of expertise that were represented in this policy-making group? Explain.

5.2 How would you define a "consumer"?

5.3 How would you define a "professional"?

5.4 How do you see consumers as contributing to the development of social policy?

5.5 Do you think that there was much consumer input into the development of policy for the NCSP? Expand.

5.6 As a key player in the development of this policy, what was your major aim?

5.7 What is your opinion of the "workings" of the policy-making group i.e. how it functioned?

5.8 What were the significant stages/steps/phases of the policy-making process?

5.9 What, in your opinion, were the critical aspects that needed to be considered in the development of the policy for the NCSP? (e.g. economic, political, personal, health, equity etc.)

5.10 If a consumer representative:
How did this representation work?

5.11 If not a consumer representative:
How, in your opinion, did consumer representation work out?

5.12 Overall, what problems were there in the development of this policy?
- from a consumer perspective
- from a professional perspective

5.13 Overall, what advantages were there in this particular process of policy development?

5.14 If you had to do it again, what, if any, changes would you like to make to the overall policy-making process?

Wed, Mar 11, 1992

~ CLIP ~

Document 1

DOCN 000011926

TI Cervical campaign begins

FS A national cervical screening campaign was launched today, more than three years after Dame Silvia Cartwright recommended the programme be set up.

SO Evening Post 910903

LO 0011247

Document 5

DOCN 000016244

TI Speech given by the Associate Minister of Health, Katherine O'Regan, at the National Cervical Screening Campaign - Wellington launch.

FS Greetings, Kia Ora, Kia Orana, Ni Sa Bula, Fakaalofa Lahi Atu, Talofa Lava, Taloha Ni, Malo E Lelei.

SO 910903

LO 00015479

Cervical Screening Programme. May 1990 —

led, Mar 11, 1992

- CLIP - For your information

Document 1

DOCN 000000136
TI Screening project planner sought
FS The Bay of Plenty Area Health Board moved a step closer to establishing a cervical screening programme last week with advertisements for a programme planner
SO Bay of Plenty Times 2 May 1990 900502
LO 00000114
KW Cervix Neoplasms - prevention and control - Bay of Plenty

Document 2

DOCN 000000395
TI Cervical screening programme draws criticism
FS All is not well with the national cervical screening programme, the Manawatu-Wanganui Area Health Board was told yesterday.
SO Wanganui Chronicle 24 May 1990 900524
LO 00000350

Document 3

DOCN 000000664
TI Cervical screening plans on target
FS The plan for Wairarapa's cervical screening programme should be in the hands of the Wellington Area Health Board by August.
SO Wairarapa Times-Age 18 June 1990 900618
LO 00000586

Document 4

DOCN 000001744
TI Screening delays may cost \$14m
FS AS MUCH as \$14 million of the \$35 million the Government allocated for the national cervical screening programme recommended in the Cartwright report may be lost because of delays in implementation.
SO Dominion 2 October 1990 901002
LO 00001609

Document 5

DOCN 000001844
TI Labour's health policy ridiculed by Pritchard
FS Napier's National candidate Colleen Pritchard has ridiculed the Labour Party's health policy directing more money toward cancer research, saying Labour still had not implemented the cervical screening programme which was described as "urgent".
SO Hawkes Bay Herald-Tribune 28 September 1990 900928
LO 00001694

Document 6

DOCN 000002075
TI Board goes it alone with screening plan
FS Wellington Area Health Board, frustrated with delays in implementing the national cervical screening programme called for by Judge Silvia Cartwright in 1988, is looking at going it alone.

Wed, Mar 11, 1992

~ CLIP ~

SO Dominion 5 October 1990 901005
 LO 00001921

Document 7

DOCN 000002101
 TI Call for action on Wellington cancer checks
 FS Wellington Area Health Board members want immediate action
 on the national cervical screening programme.
 SO Evening Post 5 October 1990 901005
 LO 00001941

Document 8

DOCN 000002127
 TI Maori-only programme sought
 FS Manawatu Maori women will ask the Manawatu-Wanganui Area
 Health Board to approve their proposal for a separate cervical
 screening programme.
 SO Evening Standard (Manawatu) 16 October 1990 901016
 LO 00001973

Document 9

DOCN 000002147
 TI \$4.5m for cervical screening plans
 FS The national cervical screening programme recommended in the
 1988 Cartwright report has been given \$4.5 million by Health Minister
 Helen Clark.
 SO Dominion 19 October 1990 901019
 LO 00001989

Document 10

DOCN 000002148
 TI \$4.5m boosts cervical screenings
 FS The Government has announced interim funding of \$4.5 million
 for the cervical screening programme.
 SO Press (Christchurch) 19 October 1990 901019
 LO 00001990

Document 11

DOCN 000002287
 TI Women's lives at risk, says Caygill.
 FS The Government's suspension of \$4.5 million in spending
 on a national cervical screening programme will put women's
 lives at risk, says the Opposition spokesman on finance, Mr
 David Caygill.
 SO Press (Christchurch), 17 November 1990 901117
 LO 00002112

Document 12

DOCN 000002493
 TI Talks on future of cervical screening
 FS Associate Health Minister Katherine O'Regan will discuss the
 future of the national cervical screening programme with the Health
 Department this week.

ed, Mar 11, 1992

~ CLIP ~

O Evening Post 21 November 1990 901121
 O 00002342

Document 13

DOCN 000002633
 TI Coast concern for cervical screen cuts
 FS "Very disappointed and concerned" is the reaction of West Coast cervical screening programme manager, Ms Ruth Teasdale, on hearing the Government's decision to suspend the \$4.5 million national cervical screening programme.
 SO Westport News 19 November 1990 901119
 LO 00002465

Document 14

DOCN 000002642
 TI Disappointed at Cervical Screening Suspension
 FS "Very disappointed and concerned" is the reaction of West Coast cervical screening programme manager; Ms Ruth Teasdale, on hearing the Government's decision to suspend the \$4.5 million national cervical screening programme.
 SO Greymouth Evening Star 19 November 1990 901119
 LO 00002474

Document 15

DOCN 000002646
 TI Cervical screening funding worry
 FS The Canterbury Area Health Board is unlikely to have the money for a full cervical screening programme if the Government pulls the plug on funding.
 SO Christchurch Star 20 November 1990 901120
 LO 00002477

Document 16

DOCN 000002652
 TI Cervical screening programme to go ahead
 FS The national cervical screening programme recommended in the Cartwright Report and put on hold last week by the Government would go ahead, Associate Health Minister Katherine O'Regan said yesterday.
 SO Dominion 21 November 1990 901121
 LO 00002483

Document 17

DOCN 000002687
 TI Cervical screening programme to go ahead
 FS The national cervical screening programme recommended by the Cartwright inquiry would go ahead, Associate Health Minister Katherine O'Regan said yesterday.
 SO Dominion 24 November 1990 901124
 LO 00002515

Document 18

DOCN 000002719

Wed, Mar 11, 1992

~ CLIP ~

TI Cervical screening programme gains endorsement
 FS Taranaki health authorities have eagerly endorsed the announcement of \$4.5 million interim Government funding for a cervical screening programme.
 SO Wanganui Chronicle, 20 October 1990 901020
 LO 00002543

Document 19

DOCN 000002802
 TI Screening likely to stay.
 FS Commitment to the cervical screening programme in Nelson-Marlborough meant it was likely to continue despite a funding suspension, says the programme manager.
 SO Nelson Evening Mail 17 November 1990 901117
 LO 00002627

Document 20

DOCN 000002859
 TI Board grant announced.
 FS Health Minister Helen Clark announced on Thursday that the Taranaki Area Health Board would be granted \$201,000 to establish and run a cervical screening programme in the region.
 SO Taranaki Daily News, 20 October 1990 901020
 LO 00002673

Document 21

DOCN 000002870
 TI Cancer screening : Maori job priority.
 FS The appointment of a Maori co-ordinator to the Waikato Area Health Board's cervical screening programme is one of the first priorities now. Government funding has been received, says programme manager Maureen Anderson.
 SO Waikato Times, 24 October 1990 901024
 LO 00002677

Document 22

DOCN 000002882
 TI Wairarapa to share in \$500,000 grant - Cervical screening on way.
 FS A cervical screening programme is to be introduced in Wairarapa following a nationwide Government funding boost of \$4.5 million.
 SO Wairarapa Times-Age 20 October 1990 901020
 LO 00002745

Document 23

DOCN 000002917
 TI Funding settled for cervical screening plan
 FS The Wellington Area Health Board is to receive \$504,000 from the Government, to implement a cervical screening programme.
 SO Evening Post 19 October 1990 901019
 LO 00002765

Wed, Mar 11, 1992

~ CLIP ~

Document 24

DOCN 000002933
 TI Cervical screening programme could start next June.
 FS The national cervical screening programme should be in place by June next year, programme co-ordinator Gillian Grew said today.
 SO Wairarapa Times-Age 29 August 1990 900829
 LO 00002751

Document 25

DOCN 000003054
 TI Cancer group struggling to survive
 FS The consumer advisory group to the Wairarapa cervical screening programme faces a dubious future.
 SO Wairarapa Times-Age 16 October 1990 901016
 LO 00002886

Document 26

DOCN 000003368
 TI Decision is welcomed.
 FS The Government's plans to proceed with the national cervical screening programme has been welcomed by West Coast Area Health Board cervical screening programme manager, Ruth Teasdale.
 SO Greymouth Evening Star 27 November 1990 901127
 LO 00003169

Document 27

DOCN 000003374
 TI HB Maori target of cervical plan.
 FS Maori and ethnic women will be the target of a regional cervical screening programme co-ordinated by the Hawke's Bay Area Health Board.
 SO Hawke's Bay Herald-Tribune November 1990 9011
 LO 00003172

Document 28

DOCN 000003388
 TI Cervical screening programme draws criticism
 FS All is not well with the national cervical screening programme, the Manawatu-Wanganui Area Health Board was told yesterday.
 SO Wanganui Chronicle 24 May 1990 900524
 LO 00003267

Document 29

DOCN 000003522
 TI Cervical screen gets green light.
 FS The Government's plans to proceed with the national cervical screening programme has been welcomed by West Coast Area Health Board cervical screening programme manager, Ruth Teasdale.
 SO Westport News 27 November 1990 901127
 LO 00003314

ed, Mar 11, 1992

~ CLIP ~

Document 30

DOCN 000003561
 TI Screening postponed
 FS The Auckland cervical screening programme has been put off until the Government makes a commitment to funding it.
 SO New Zealand Herald 27 November 1990 901127
 LO 00003384

Document 31

DOCN 000003638
 TI Views on screening programme.
 FS Politicising the cervical screening programme was leading to a disastrous situation, Charles Noble (Wanganui) told the Manawatu-Wanganui Area Health Board yesterday.
 SO Wanganui Chronicle 23 November 1990 901123
 LO 00003444

Document 32

DOCN 000003657
 TI Subsidy cut setback to programme.
 FS The Marlborough Cervical Screening Programme Committee is worried that local women have lost the incentive to register for cervical screening following a recent Government decision to axe the \$11 smear consultation subsidy.
 SO Marlborough Express 3 December 1990 901203
 LO 00003461

Document 33

DOCN 000003846
 TI Canty asked to pilot cervical screening.
 FS Canterbury has been asked by the department of Health to pilot the cervical screening programme.
 SO Christchurch Star 19 Dec 1990 901219
 LO 00003625

Document 34

DOCN 000004013
 TI Board plans cervical action.
 FS The Bay of Plenty Area Health Board is planning a cervical screening programme for women in the region.
 SO Bay of Plenty Times 15 August 1990 900815
 LO 00003770

Document 35

DOCN 000004212
 TI Cervical screening begins.
 FS A cervical screening programme has begun in Canterbury despite uncertainty over its funding from the Government.
 SO Christchurch Star, 4 December 1990 901204
 LO 00003916

Document 36

DOCN 000004214

Wed, Mar 11, 1992

~ CLIP ~

TI Funding delays hurt programme.
 FS The cervical screening programme will "fade into the distance" if delays continue, Southland Consumer Smear Takers Committee chairperson Jean McDonald said yesterday.
 SO Ensign, 30 November 1990 901130
 LO 00003918

Document 37

DOCN 000004278
 TI Screening can prevent cancer. [Letter]
 FS A recent Herald editorial made the comment that the proposed cervical screening programme "has been celebrated out of all proportion to the incidence of the disease it monitors," and a correspondent asked why cervical cancer was getting so much attention when breast cancer, which kills more New Zealand Women annually, does not.
 SO New Zealand Herald, 18 December 1990 901218
 LO 00003978

Document 38

DOCN 000004301
 TI Peters backs cervical screening.
 FS Support for the proposed national cervical screening programme - deferred by the National Government - has come from the Minister of Maori Affairs, Mr Peters.
 SO Press (Christchurch), 11 December 1990 901211
 LO 00004000

Document 39

DOCN 000004376
 TI Board to pilot cervical plan.
 FS The Canterbury Area Health Board has accepted an invitation to be the "fast-track" board for the implementation of the proposed national cervical screening programme.
 SO Press (Christchurch) 13 December 1990 901213
 LO 00004069

Document 40

DOCN 000004425
 TI New manager appointed for screening programme.
 FS The next few months are going to be fairly high powered ones for those involved in getting the Southland cervical screening programme up and running.
 SO Ensign 10 July 1990 900710
 LO 00004106

Document 41

DOCN 000004765
 TI Screening was inevitable, says Clark.
 FS Even without the Cartwright inquiry into National Women's Hospital, a nationwide cervical screening programme would have been set up, Health Minister Helen Clark says.
 SO Evening Post 2 July 1990 900702
 LO 00004412

Wed, Mar 11, 1992

~ CLIP ~

Document 42

DOCN 000004777
 TI Lower costs important for screening.
 FS Having both male and female doctors and a low-cost service are important to the success of the Wairarapa cervical screening programme, according to the Wairarapa task force.
 SO Wairarapa Times-Age 30 July 1990 900730
 LO 00004424

Document 43

DOCN 000004788
 TI Smear test official starting work.
 FS Cervical smears will probably be done in future by trained lay smear takers as well as professionals, according to the Southland Area Health Board's new cervical screening programme manager, Karen McCarthy
 SO Southland Times, 10 August 1990 900810
 LO 00004428

Document 44

DOCN 000005134
 TI Women's lobby criticises new group
 FS Women's groups, including maori and Pacific Island representatives, are concerned the quality of the national cervical screening programme might suffer, now that the expert group overseeing it has been disbanded
 SO Evening Post 02 February 1991 910202
 LO 00004767

Document 45

DOCN 000005135
 TI loss of expert group 'a disaster"
 FS Disbanding the expert group set up to oversee the national cervical screening programme is a win for Health Department bureaucrats and a loss for women, according to former health minister Helen Clark.
 SO Dominion 02 February 1991 910202
 LO 00004768

Document 46

DOCN 000005144
 TI Women's view vital in screening plan
 FS Government plans for funding a national cervical screening programme, announced today, have been criticised for not including input from ordinary women.
 SO Auckland Star 1 February 1991 910201
 LO 00004777

Document 47

DOCN 000005304
 TI Cervical screening grant cleared
 FS The Southland cervical screening programme has got the go-ahead with the release of a \$152,000 grant from the Health Department this week.

Wed, Mar 11, 1992

~ CLIP ~

SO Southland Times 16 February 1991 910216
 LO 00004922

Document 48

DOCN 000005370
 TI Funds bring cervical screening closer
 FS A cervical screening programme for the Bay of Plenty moved closer
 this week with the announcement of \$245,000 funding by the Department
 of Health.
 SO Rotorua Post 19 February 1991 910219
 LO 00004983

Document 49

DOCN 000005376
 TI go-ahead for cervical screen project
 FS Wellington's cervical screening programme has received the official
 go-ahead with the release of funds set aside by the pervious government
 SO Evening Post 20 February 1991 910220
 LO 00004989

Document 50

DOCN 000005517
 TI Screening plan to minister
 FS A cervical screening programme for the Bay of Plenty has been
 approved by the area's health board members.
 SO Rotorua Post 25 January 1991 910125
 LO 00005121

Document 51

DOCN 000005982
 TI GPs "obstructing" screening programme
 FS The national cervical screening programme subject to repeated
 delays since recommended by Judge Silvia Cartwright in 1988, is now
 being obstructed by some general practitioners according to
 programme co-ordinators.
 SO Dominion 05 March 1991 910305
 LO 00005553

Document 52

DOCN 000006246
 TI Islanders, Maori get smear test priority.
 FS Maori and Pacific Island women will get top of the list when the
 Hawke's Bay Area Health Board's cervical screening programme gets under
 way in May this year.
 SO Hawke's Bay Herald-Tribune 7 March 1991 910307
 LO 00005769

Document 53

DOCN 000006484
 TI Funds for cancer screening over to board
 FS Funds to complete a cervical screening programme in
 Wellington are no longer to be set aside by the Health

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SO Evening Post 910320
LO 00005985

Document 54

DOCN 000006560
TI SC likely to get cervical screening programme
FS The Canterbury Cervical Screening programme is likely to be extended to South Canterbury this year, and a public meeting to discuss its implementation has been arranged for 1 May
SO Timaru Herald 910315
LO 00006089

Document 55

DOCN 000006902
TI Call for screening funds
FS Screening programmes for cervical cancer needed long-term funding to be effective, Wellington Area Health Board cervical screening programme co-ordinator Kathleen Gavigan said yesterday.
SO Dominion 910320
LO 00006375

Document 56

DOCN 000006904
TI Assurance given on cervical screening
FS Associate Health Minister Katherine O'Regan has given an assurance the national cervical screening programme will continue to be funded, though not specifying the amount of money available.
SO Dominion 910322
LO 00006377

Document 57

DOCN 000007844
TI Cancer register ultimate aim
FS Tairāwhiti Area Health Board's cervical screening programme, aimed at saving lives and reducing suffering caused by cervical cancer was officially opened yesterday.
SO Gisborne Herald 910507
LO 00007420

Document 58

DOCN 000008364
TI Marae clinics plan proposed
FS Marae-based cervical screening clinics have been proposed as part of the Bay of Plenty Area Health Board's cervical screening programme.
SO Bay of Plenty Times 910510
LO 00007804

Document 59

DOCN 000009213
TI Display targets cervical screening
FS A cervical screening programme is the subject of the first display

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in the old Trustbank premises in Waverley.

O Taranaki Daily News 910608
O 00008668

Document 60

OCN 000009391
I Health Department explains advice costs
S Policy advice that cost the Health Department \$35 million last year included implementation of the cervical screening programme, monitoring of imported food, and other operational costs
O Dominion 910613
O 00008846

Document 61

OCN 000009849
I Appeal made to doctors for change of attitude
S An appeal has been made to Wanganui doctors to change their minds and support a national cervical screening programme.
O Wanganui Chronicle 910627
O 00009301

Document 62

OCN 000010949
I Optimism about screening
S There is optimism over the future of the West Coast Area Health Board's cervical screening programme despite a big drop in funding
O Greymouth Evening Star 910808
O 00010338

Document 63

OCN 000011326
I Health board savings sufficient to cover planned projects
S Southland's cervical screening programme and some mental health projects are safe, after the Southland Area Health Board found money to fund them
O Southland Times 910817
O 00010692

Document 64

OCN 000011496
I Cervical screening seen as success
S The Canterbury cervical screening programme has enrolled 3000 women since it started late last year and should have 16,500 on its books by June 1992
O Christchurch Star 910805
O 00010850

Document 65

OCN 000012251
I Coast Response to Cervical Screening Best in Country
S The response from West Coast women to a cervical screening programme has been the best in the country.

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~ CLIP ~

) Greymouth Evening Star 910829
) 00011561

Document 66

OCN 000013436
 I Nelson woman wins national cervical job
 S The head of nursing studies at Nelson Polytechnic has been
 appointed the country's first national co-ordinator of the cervical
 screening programme for the Health Department
) Nelson Evening Mail 900406
) 00012707

Document 67

OCN 000013791
 I Local women keen to screen
 S Manawatu and Wanganui women have responded to the national cervical
 screening programme better than women anywhere else in New Zealand.
) Evening Standard (Manawatu) 911018
) 00013054

Document 68

OCN 000013814
 I Women urged : have cervical smear test
 S All women who have never had a cervical smear test are being urged
 to do so by the head of Canterbury's cervical screening programme,
 Margaret Radford.
) Christchurch Star 911009
) 00013077

Document 69

OCN 000014061
 I Cervical screening programme gets funding push
 S New Zealand's cervical screening programme took a big step forward
 today, with the announcement of \$4.5 million interim Government funding
 to area health boards
) Media statement 901018
) 00013324

Document 70

OCN 000014691
 I Caution urged on alternative health carers
 S Women must be warned against allowing cervical cancer screening tests
 to be conducted by unregistered people, the Bay of Plenty Area Health
 Board's cervical screening programme planner, Heather Yamamoto said
) Rotorua Post 911109
) 00013934

Document 71

OCN 000015128

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I Waikato smear numbers up in campaign's wake
 S The number of Waikato women having cervical smears has increased
 markedly since the launch of the national publicity campaign, says the
 manager of Waikato Area Health Board's cervical screening programme
 O Waikato Times 911130
 O 00014363

Document 72

OCN 000015232
 I Screening-register plea
 S Canterbury's cervical screening programme is calling on more doctors
 to support the screening register in the region
 O Press (Christchurch) 911204
 O 00014507

Document 73

OCN 000016243
 I Cervical screening media campaign a success
 S The media campaign to publicise the Government's cervical screening
 programme is a success, Associate Minister of Health Katherine O'Regan
 said.
 O Minister of Health Press Release 920119
 O 00015478

Document 74

OCN 000016265
 I Test charges anger women
 S Charging women for cervical smears defeats the purpose of setting up a
 cervical screening programme, angry Nelson women's groups and nurses sai
 d today.
 O Nelson Evening Mail 920121
 O 00015498

Document 75

OCN 000016867
 I Interpreting the Treaty (letter)
 S Green Lane/National Women's Hospital is advertising for an executive
 manager for its cervical screening programme
 O Evening Post 920206
 O 00016051

Document 76

OCN 000017551
 I Protest leads health board to reduce smear charges
 S The Nelson-Marlborough Area Health Board has reduced its user
 part-charges for women having cervical smears, after protests from the
 local cervical screening programme co-ordinator
 O Marlborough Express 920225
 O 00016716

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Document 77

DOCN 000017617

TI Clinic for Samoan women

FS Samoan women will be the focus of a Canterbury Cervical Screening programme on Saturday.

SO Press (Christchurch) 920228

LO 00016784

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